NHS
National Institute for
Mental Health in England
North East, Yorkshire and Humber Mental Health Development Centre

AT HOME?

A study of mental health issues arising in social housing

"Mental health problems require more than a medical solution; they require a positive response on the part of society to accommodate people's individual needs and to promote mental well-being."

"Action will be needed across government to improve the current experiences of people with mental health problems. The problem… cannot be solved by any one department acting in isolation."

Mental Health and Social Exclusion
Social Exclusion Unit report, ODPM, June 2004[i]

"Housing should be seen as an integral part of any support package."

"Giving people their own front door really works. But what we have to do, is to make them feel that we are interested in helping them turn that house into a home."

"There needs to be some procedure to ensure that information on a service user's needs is available at the local housing office. Or maybe not to everyone there – just to a few."

"People are just moved from property to property without any problems being resolved."

"It's very rare that we refuse to house somebody because of their mental health problems; only if it's quite clear that they can't manage on their own."

"It's just not acceptable to keep us in the dark about problems, just to get re-housing."

"But of course, if you're homeless and desperate, you'll have to take whatever comes…".

"What I would like to see is joined-up targets!"

"Housing management remains the backstop of community care."

[All quotations are from interviews with housing services staff]

Inner covers: Sample quotations

Contents

1: Introduction

1.1 THE NIMHE INTER-AGENCY PARTNERSHIP

The present study is one of several initiatives that have arisen from the mental health social inclusion and housing inter-agency partnership, originally developed by the North East, Yorkshire, and Humber Regional Development Centre of the National Institute for Mental Health for England, or NIMHE.

It forms part of a programme of activity, launched at a multi-stakeholder consultative workshop at the end of 2003, to contribute towards better understanding and joint-working between housing and mental health services. This study is therefore one "strand" of a broader development agenda, whose ambition is to promote wider social inclusion for people with mental health problems.

This report, based on original survey fieldwork, is intended to gather and express the views and experiences of housing staff on the challenges of working with individuals with mental health problems, and on what they would see as good practice in this field. It builds upon, up-dates and extends a very valuable study conducted in the mid-1990s in a similar and neighbouring area[ii].

In addition, where there is a need and a desire for change – and it is clear from the findings so far that there is both – we need to appreciate better what the drivers for change might be, and what the restrictions or inhibiting factors. This is best done at a local level. This report will need to be followed by local dialogue between agencies to discuss the issues raised in their local context, and to consider the recommendations that follow.

The inception in 2005 of the NIMHE Housing Reference Group (NHRG), bringing together key national agencies in housing and mental health to guide the implementation of the Social Exclusion Unit's recommendations[iii] on housing, creates a unique opportunity for discussion and dissemination of more "joined up" practice. The subsequent incorporation of NIMHE into the Care Services Improvement Partnership (CSIP), and the development of the National Social Inclusion programme, now allows for a wider relevance for work to bring housing and community care services more effectively together.

1.2 WHY HOUSING?

But why study ordinary housing services? It is obviously true that many - the great majority - of people with mental health problems, including those with severe and enduring problems, live in ordinary housing. That has been, after all, the principal intention of Care in the Community policies for a generation. But is there something special about housing?

The simple answer is, "Yes". If social inclusion means ensuring that all individuals, despite any particular perceived "different-ness" or disadvantage in life, may nevertheless feel at home in the world, and find a sense of belonging in their local community, the most important place to feel at home, is at home.

Good quality, affordable, safe and suitable accommodation is one of the cornerstones of well-being[iv], and individuals with mental health difficulties are no different in this respect from any others in society. Alongside financial security, constructive activity, and a welcoming family or social circle, better housing is one of the most common aspirations[v] of service users, and their carers.

For many people, access to decent housing, with the appropriate support if need be to help manage the ordinary tasks of living, is the key to a better quality of life, a positive relationship with immediate neighbours, independence and an accepted "place" within the local community.

> *"Housing management is about integrating people into their community, and dispersed housing is all about social inclusion."*
> .
> *"We need to make it clear that we are interested in helping them turn this place into a home"*

1.2.1: THE EVIDENCE FOR HOUSING DISADVANTAGE

Yet there is strong evidence to suggest that people who are assisted by mental health services are at a disadvantage in the housing market.

- Those with mental health problems are significantly under-represented in owner-occupier housing – generally seen as the most socially valued and secure housing in contemporary Britain[vi].
- Mental health problems figure highly in the identified risk factors for tenancy breakdown[vii] (just as housing problems, in turn, figure highly in the triggers for admission or re-admission to psychiatric care[viii]).
- Many studies indicate a very high prevalence of mental health disorders amongst homeless people[ix].
- Studies of medical priority re-housing and of area-based neighbourhood renewal initiatives indicate that they significantly benefit residents in reducing individual ill health, including in particular mental health[x].

- There are consistently higher concentrations of individuals with mental health problems in inner city areas[xi], where poor housing – including overcrowding, multi-occupancy dwellings, and a dependence on high-rise accommodation[xii] – is found to exacerbate mental health difficulties[xiii].

Coping with household finances, bills, and the complexities of the benefits system; organising practical tasks, such as basic repairs and upkeep; sustaining relationships with neighbours, and with the landlord, can be demanding at times for us all.

But these aspects and responsibilities of ordinary living are harder for those who are also struggling with mental or emotional difficulties, the sedative or other side-effects of medication, isolation, and the misunderstanding and stigma that still all too often accompany and exacerbate poor mental health.

Yet studies indicate that, where rehousing can take place as a result of priority given to people with poor mental health, it is particularly effective[xiv] at relieving distress. This suggests that mental health difficulties may be particularly responsive to poor housing or to an improvement in housing circumstances.

1.2.2: WORKING WITH HOUSING SERVICES

Nevertheless, is it so important to seek the views of housing staff? After all, we know that low income and transport difficulties also have a significant impact on social exclusion for those with mental health problems; but this study did not interview Benefits Agency staff, or rural bus drivers.

The answer, again, is "Yes". The role of a housing officer is substantially one of tenancy management, involving considerable levels of interpersonal skills, the ability to resolve conflict and professional training to cope with legal and financial issues on a human level. As such, their skills frequently complement those of mental health staff in securing a stable and supportive environment for those with adverse mental health.

Housing services may often be the first to become aware of problems and warning signs, when a tenant is struggling. But housing staff are frequently unclear as to how to respond appropriately. How to identify and respond to concerns that may require specialist professional intervention presents a problem - when and who to call? Staff have reported feeling under-informed on mental health issues, and on the organisation and function of mental health services. It is still relatively rare for housing staff to be involved in care programme planning.

Nevertheless, there is also much good work, often under-recognised, carried out by housing staff as individuals with mental health problems are offered suitable properties. It is easy to underestimate the difficulty of identifying properties and locations for people with emotional or behavioural patterns linked with poor mental health. The allocations officer does not just have to consider the "now" of satisfying a client, but the "ever after" of maintaining a balanced and harmonious community. The housing officer will know very quickly if the allocations officer has got it wrong.

Yet there remains a common perception in mental health circles that housing services are often reluctant to house those with mental health problems, and that mental health service users are more likely to find themselves in sub-standard accommodation in less attractive parts of the locality. It may be that housing services are indeed sometimes reluctant to house those known to have mental health problems, fearing – from past experience - that there will be insufficient support from statutory services when problems arise with the tenancy.

A closer dialogue is needed between mental health and housing services, to find out how far this perception is accurate, and if so, what the underlying reasons may be, and how they can be addressed. Do allocations processes take into account the whole needs of the person, or solely their housing needs? Do choice-based-lettings approaches – developing a consumer-led approach to allocation of properties - make sufficient allowance for the difficulty vulnerable individuals may have in engaging with the process?

More generally, are there institutional processes that work, unwittingly, to the disadvantage of those with mental health problems? Have developments in homelessness legislation and case law led to more, or to less flexibility in identifying vulnerability? What effect has the recent growth in "tenancy sustainment" support services had, on both the fears and the reality? It is perhaps particularly important to know whether poor communication channels between mental health and housing services exacerbate the situation.

Processes, experience, and insights are hard to identify through quantitative approaches. This exploratory study was therefore designed within an action learning framework, to seek in some depth the views of housing staff. This participatory research framework also reflects the belief that improvements in service that staff have themselves identified and contributed to have more long-term value, and more genuine impact, than any number of performance indicators imposed upon a service from without. The implications of any findings from this work should lead to new learning, at local level. Such local dialogue is valuable in itself.

The study was carried out under the auspices of the National Institute for Mental Health for England, as part of the partnership programme for mental health, housing and social inclusion. The original research was carried out by RJA consultancy, an independent research and development practice which specialises in mental health and housing issues.

The study benefited from the in-put of a small steering group, with membership drawn from a range of agencies working in this area. These individuals gave their time in reading sometimes lengthy drafts,

at inconvenient times, and also attended meetings to discuss and un-pick complex and entangled issues. We are grateful to them all for their time and advice. The final report also benefited from comments and feedback at various stages from many sources, including members of the NIMHE/CSIP Housing Reference Group.

We at RJA must take full responsibility, however, for any errors and confusions remaining. Neither the overall findings nor the specific recommendations should be taken as reflecting the views of NIMHE, but rather as a contribution to the discussion on which NIMHE/CSIP is leading.

1.3 THE STUDY FRAMEWORK

HJONES 12/12/05 09:36
Formatted: Bullets and Numbering

1.3.1 : THE INTENTION

The overall purpose of the general needs housing study programme was:

- to convey to mental health services an accurate picture of the issues for housing services, and of emerging good practice, that can be recognised and promoted.
- to assist housing and mental health agencies to develop good practice, and ensure their service operates as effectively as possible to identify and address the needs of tenants with mental health problems.

There were therefore two central questions that we sought to answer:

1. What would housing staff like to see their organisation doing to improve their service to people with mental health needs?
2. What would they want from other agencies – and particularly the statutory mental health and social services – to enable them to improve their service as they would wish to?

Bearing in mind earlier feedback from both service users and carers, and from housing staff, we were particularly interested in the approach of each housing organisation to:

- Allocation of properties
- Assessment of vulnerability that determines priority need under the homelessness legislation
- Medical recommendations for re-housing
- Any existing communications channels or protocols between housing and mental health services
- Other existing procedures or mechanisms for identifying and responding to the mental health needs of tenants
- Any identified training needs for staff

But we made it clear throughout that we wished to ask about any kind of changes, developments or other in-put that staff themselves believed would enable them to help those vulnerable through mental illness to successfully maintain tenancies in ordinary housing. We stressed that we were interested

in any examples of current good practice that they would like to see recognised.

1.3.2: THE SAMPLE FRAME

For this survey, NIMHE's North East, Yorks and Humber Regional Development Centre identified six local authority areas within their region. These areas, it was felt, provided a broadly representative sampling (but see the "scope and limitations of the study" section earlier), with some common themes. They were also sufficiently closely clustered geographically as to allow the possibility, following on from the initial research and survey work, of on-going contacts in the development of one or more local good practice benchmarking groups, if the participating authorities and agencies so chose.

The interview team set out to interview equal numbers of general needs housing staff from both local authorities and local Housing Associations (or "RSLs"). We were keen to interview both frontline staff and senior managers, i.e. those responsible for both policy and implementation. Nevertheless, we needed to recognise that each area, each authority and agency, has different issues and a different structure, and therefore we could not be too precise or too prescriptive over whom we would hope to involve.

Finally, our prime concern was with adult mental health issues, rather than with dementia, substance abuse or learning difficulties, which are specialised areas in their own right. Nevertheless, although we were not here looking at specialist mental health accommodation schemes, we were conscious that individuals with mental health needs may at times be living in sheltered or retirement housing, and the issues around identifying their needs and managing these issues may be comparable. If so, we were keen to hear the experiences of staff managing sheltered accommodation. Therefore for our purposes, "general needs housing" could include sheltered or retirement housing for older people and those with disabilities.

Before proceeding, however, we must stress three important reservations.

Complexity

Social housing is exceptionally variegated, and is going through a period of change, both in its role and in its organisation – as of course are mental health and support services. The views expressed are drawn from a wide variety of services and models, each in transition.

Whilst an attempt has been made to place the range of views expressed in context, and relative to the role of each respondent in their own organisation, this has required a degree of interpretation, and of generalisation, of the view expressed.

Asymmetry

This study explored the views and experiences of housing staff over issues of mental health that they encounter in their daily work, and of what they thought is, or would be, good practice. This study, and this report, was not intended as

an evaluation of particular services, and we cannot in any case at this stage claim to have identified good practice, but rather to report on what housing practitioners themselves believe to be effective, valuable, and most needed.

The result so far is a picture of the state of communications and relations between mental health and housing services, as expressed by the workers on one side only of what appears at times as a deep structural divide in social policy and provision.

It is perfectly possible that, if mental health workers were now similarly interviewed in the same depth to elicit their views of housing, we would find some strongly contrasting views. This study, and this report, need to be seen as a contribution to an on-going dialogue – albeit one that many have suggested is long overdue. In this sense, the study is simply one part of an on-going learning process, which needs to continue at local level.

Locality

It is the inevitable fate of all research to conclude that more research is needed. For example, the sampling frame – services in six neighbouring local authority areas on an east-west axis running north of the geographical centre of the country – may not capture adequately marked regional variations in housing demand.

Similarly, the geographic area of the study does not include a sufficiently representative range of housing services that are BME led and BME focussed to address mental health needs. We have not been able to comment on issues that affect minority communities as much as we would have wished. In view of widespread concerns over the over-representation[xv] of Black African and Caribbean males in statutory mental health services[xvi], different approaches to the provision of housing related support to this community could be a fruitful subject for future research.

Nevertheless we believe that the sample reflects the national picture, albeit with local variations in the ways that the issues are expressed and addressed, insofar as the organisational processes that have been identified in this locality, operate nationally.

1.3.2: INTERVIEWING

We opted for face-to-face interviews wherever possible, in the interviewees' own workplace, allowing approximately one hour per interview – with time to run over – in order to go into greater depth into any areas the interviewees might choose. Interviews were informal in style, and the questions largely open-ended. We were not assuming that we already knew what the right questions to ask were.

Nevertheless, in order to introduce some focus, and to enable broad coherence which would allow us to compare and collate what would inevitably become a very wide range of views from staff with a wide range of experiences and

"angles", we did use some standard questions with all interviewees. These were:

- What might suggest to you that a tenant (or an applicant for a tenancy) may have unacknowledged mental health problems?

- What has been your experience of attempting to contact mental health team staff, when concerned about a particular tenant?

- What difference – if any – has Supporting People, and the development of floating support services, made to the way your services manages, or thinks about working with people with mental health problems?

- Are there particular examples of good practice that you would like to see more broadly adopted?

In addition, wherever it seemed relevant, we also asked Housing Association staff (principally but not exclusively managers) whose territory crosses health and/or local authority boundaries:

- Are you aware of any significant difference in the way that differing mental health services manage these issues?

For Local Authority staff (principally but not exclusively managers), we asked:

- Can you suggest a practical way in which the housing perspective could be better represented in, or integrated into, community care and joint commissioning processes?

- In your experience, has the Homelessness Act 2002 lead to any closer communications locally between housing and mental health services over the nature of vulnerability?

Finally, towards the close of the interview, we would ask of all interviewees:

- If you had three wishes, for changes and improvements that you would like to see in local services, that would significantly improve the housing circumstances of people with mental health problems – what would you wish for?

- And if you only had one wish, for your top priority out of those three, which would it have to be?"

The bulk of recording of views and experiences was verbatim, in the course of the interviews, with direct quotations wherever possible, fed back to the interviewer, to check that this was an accurate description of their views.

1.3.3: ANALYSIS OF RESPONSES

Any summary of views expressed in open-ended questions, particularly in-depth interviews, is inevitably heavily dependent both on the usefulness of the

original questions, and the accuracy of the interviewers as objective reporters. The "three wishes" question, however, does lend itself to an analysis of views with some degree of greater precision and consistency.

Based on a preliminary analysis of the range of issues being raised as wishes, a simplified alphabetical coding of issues was therefore developed, which allowed this broad summary of issues raised to be fed into a spreadsheet. The range of responses could then be assessed, and the number identifying any one range of issues could be "read off". (These codes, and a sample spreadsheet analysis page, are shown in Appendix Ai and Aii.)

This novel method allows an approximate measure of the extent to which staff in different contexts raised different issues. It does not, in any way, turn this essentially qualitative methodology into a formally quantitative research approach. But it does mean that we can at times go a little further than simply saying 'most' or 'some' or 'a few' staff expressed one or another view, and we can substantiate, to that degree, any assertions as to how important any issue or range of issues was said to be. (Where we cannot do so, terms like "many" or "most" should be understood as having their ordinary English language usage.)

The spreadsheet could in principle be further analysed by contrasting, for example, responses of Local Authority and housing association staff, of frontline or middle manager staff, or of staff from one or other locality. Where these distinctions do appear significant, they are referred to in the text.

1.3.4: THE "THREE WISHES"

The analysis approach was then applied to the "three wishes" cited, this being the clearest indicator of staff's principal concerns, and the key point at which interviewees' responses were most readily comparable.

On that basis, therefore, we can say with confidence that, from the evidence here, the commonest wish, suggested by 76 staff out of 140 interviewed, was for training in mental health issues. Of these, the majority (42) wanted mental health awareness training most of all. A smaller number (24) wished for mental health awareness combined with information on accessing services; whilst a small but significant number (6) saw as a priority better mental health awareness amongst other tenants, and/or the general public.

The second commonest desire (60) was for better information on the mental health needs of tenants. The nature and the form of information could vary enormously, from those who wanted a procedure for information specifically at the point of sign-up for a tenancy (19), to those who wanted better management information, to plan services that meet identified needs and deploy resources better (14). But the bulk of requests was for information-sharing between mental health and housing agencies over ongoing problems.

The third most common wish was for strategic development and co-ordination, to improve the range of housing options for those with mental health problems. Roughly equal after that came more recognition of the role and professionalism

of housing; better joint working, and the proposal to develop mental health specialist "linkworkers" within each housing service (34, 35, 36, respectively).

Next came more structured forms of information exchange – "one-stop shops", for advice and referral, and local forums for discussion of local area issues and problems - and for meeting and building relationships (24 and20 respectively).

However, if we look, not at the three wishes bundled and counted all together, but at the top priority wish ("And if you had one wish only, what would it have to be?"), then strategic housing stock development, and a broad recognition by mental health workers of the role and potential of working with housing, come to the fore (18 and17). This is closely followed by joint working, and the development of linkworkers within housing teams (16 in both cases).

The conclusion appears to be that these housing staff positively welcomed a new and recognised role for housing services as a partner, both at strategic and at individual levels, within the broader network of services for people with mental health problems.

1.3.5: PRESENTATION OF KEY THEMES

The central section of this report outlines the key themes that arose in the course of the interviews. These themes cover those activities or structures most frequently cited as good practice wherever they have been developed locally; but they are also those that were most often raised as wish-list issues.

There is nevertheless a high degree of consistency between what is cited with approval where it does exist, and what is wished for, where it is not in place. We have therefore tentatively proposed that approval and demand can be taken as corroborating each other, at least in identifying the agenda for improvement.

NIMHE and the RJA consultancy will continue to gather details of examples of good practice, nationally and locally, with a view to locating such material on NIMHE's Knowledge Community website[xvii], (http://kc.nimhe.org.uk/) and/or the forums area of the National Social Inclusion Programme website (www.socialinclusion.gov.uk) to prompt further discussion there. These sites promise to become the key resources for debate and for "shareware" on innovation and good practice in this area.

The key themes that have emerged in these interviews are presented in the following section in the terms in which they are most consistently raised as issues in the survey interviews – but with some modest re-grouping to link issues that are clearly similar or overlapping, for greater coherence in presentation.

Nevertheless, there is inevitably some circularity still in the issues, as described here. This is partly because many of the issues, and the best examples of successful practice, are interdependent or mutually re-enforcing. The "picture" emerging is therefore not in the comfortable traditional style of a Constable or even a Lowry, but is more akin to a Cubist painting, with many images and aspects re-appearing from new angles.

As far as is practicable, we have used direct quotes from interviewees to make the points that they had raised – sometimes with all due complexity and paradox. This is not an area where over-simplification is helpful.

In the following section, some attempt has been made to distinguish

(a) a summary of the actual points made by interviewees;
(b) quotations, to illustrate the points made, in the words of the interviewees themselves; and
(c) commentary – our own observations on what has been said.

Summary sections are therefore shown here in ordinary type. All direct quotations are in italics (NB: with the role of the speaker identified, in grey type, but their actual identity represented only by a number, in order to preserve anonymity as promised). Our own commentary on the issues raised then appears in shaded boxes.

This attempted distinction between summary and commentary, however, cannot be watertight. If either seems inaccurate or inadequate, we hope that local dialogue will address errors and refine the overall picture.

2: The key findings

2.1 RECOGNITION

2.1.1: THE ROLE OF HOUSING SERVICES

The most frequently expressed view, throughout all these interviews, was that there is little awareness of the degree of involvement that housing staff may actually have, in the management of mental health issues of tenants. This applies both to the work being done by housing staff in sensitively housing people in relation to their needs, and to their on-going efforts in managing the difficulties that may threaten a tenancy.

A constantly repeated theme in these interviews was the perception of housing staff, at all levels, that their knowledge of the tenant and the community is an untapped resource that mental health staff rarely appreciate, and rarely make use of. The wish for better recognition was the second commonest of the "three wishes" - only marginally below the wish to see better strategic co-ordination between mental health and housing services (which is, arguably, a more practical expression of the same issue.)

Whilst many housing staff see the opportunity and the need, there seems relatively little appreciation of the potential in a more co-ordinated joint effort by housing and mental health services, working together, to identify and develop more suitable accommodation of all kinds for those with more severe mental health problems.

> *There needs to be much greater awareness of housing as a key player in community care; we shouldn't be seen as a bit part player.*
>
> *Housing services manager, LA Housing Dept [59]*

> *We need for mental health services to realise the importance of housing, as a major part of the quality of life. We're just not seen as fellow professionals. But just giving them the keys is not the end of it*
>
> *Housing Officer, LA Housing Dept [43]*

> *I'd wish for mental health services to understand what housing will do, and will be available for. Their expectations are ill-informed; they fail to realize the complexity of what we do deal with*
>
> *Lettings Officer, RSL [101]*

> *We really need for other services to recognise housing management, as a natural part of the landlord function.*
>
> *Area Housing Manager, ALMO, [20]*

At local level it is argued that services need to be more holistic. They need to consider all the needs of an individual, with fuller recognition of the importance of housing – not just supported housing.

> *There needs to be a higher profile for the social agenda in housing.*
> *Housing Strategy Officer, ALMO [35]*

> *We need to tie housing into social care planning*
> *Homelessness section Officer, LA Housing Dept [66]*

> *Housing should be seen as an integral part of any support package.*
> *Group Housing Manager, ALMO [15]*

> *We are a provision in society that would complement the work of the mental health teams.*
> *Snr Area Manager, specialist RSL [123]*

It was however also sometimes said that some senior housing managers (and indeed local politicians, as managers) do not always fully appreciate how much of mainstream housing management is in practice involved with managing sensitive issues with tenants, such as mental health related problems.

> *It took ages, well over a year, and countless visits. I think just about everybody in the office knows them, They all went out to see them, trying to resolve things.*
> *Area Housing Manager, RSL [105]*

> *I work alongside the Housing Officers in about 85% of cases. I'd say the work I do is about 50% mediation between neighbours.*
> *Specialist ASB officer, RSL [126]*

> *But it's not just mental health services. Elected members, and government, they have to remember that we are here as the* ***social*** *landlords.*
> *Asst Area Manager, LA Housing Dept [21]*

Mental health issues do appear to be seen by some in senior management as essentially the responsibility of other agencies. Therefore the workload for staff involved with dealing with the housing management aspects may not be recognised, either in the sense of being valued, or in the sense of being monitored. The potential for greater efficiency in delivering the housing task through new procedures, accepting the need and organising for the time involved, is therefore not explored.

Meanwhile, however, other senior managers are clearly fully aware, but can still be rather ambivalent, about the extent to which their staff do get deeply involved in problem-solving with tenants.

> *Housing management could perhaps be liable if our workers exceed their competence, and then it all goes wrong, without any cover from mental health services.*
>
> *Snr Housing Manager, ALMO [69]*

Just as the involvement of housing staff in resolving difficulties with individual tenants may be unrecognised, likewise many staff argued that there is little systematic development of the broader role of housing in community care, or of the potential in working more strategically. Overall, there was a view that their available housing stock was not seen as part of any planned and cohesive strategy to meet the community care needs that they find themselves in practice required to meet.

At a more strategic level, some staff have suggested that a more corporate approach to the analysis of housing needs, and to the development of new schemes, is needed. Some – mainly middle or senior managers - have suggested that what is required is better management information, to help identify the needs and better deploy the resources to meet those needs – both with staff time and housing stock.

Still others have suggested the need for new performance indicators, to assess the sensitivity of housing practice to community care issues, as the only way to offset a pre-occupation with "bricks and mortar" concerns, and to reflect the reality of their task as providing *social* housing. These broader, more strategic issues are addressed in the final sections.

In the preliminary planning stages of this study, in telephone discussions with Health and Social Services staff, users and carers in the sample frame authority areas, all concerned seemed to welcome this initiative. The aspiration of bringing better understanding and closer joint working between housing and mental health services was seen as worthwhile, and indeed, as long overdue. However, although in most areas there is a recognition at least of the need for closer working, there is little indication as yet of such recognition translating effectively into local policy and practice in frontline services.

There is clearly great scope for improvement, in a more corporate approach from local authorities. But it is equally clear that the Housing Association sector also needs to be fully involved, even where there may be logistical difficulties around different geographic boundaries for their services. Markers of good practice to be identified must take into consideration for example the fact that RSLs may vary enormously in the amount of stock they may have in any one locality, and how closely they can be involved in local practice.

2.1.2: MENTAL HEALTH NEEDS IN THE COMMUNITY

When asked if they could estimate the number or proportion of people with mental health problems living in their housing stock, or on the "patch" that they managed, the answers varied widely, between "most" and "hardly any". The range and nature of issues identified by housing staff as actually being mental health problems likewise varied enormously.

> *Hardly any. Some people with depression and anxiety, and maybe some mild personality disorders*
> Community Assistant, RSL [138]

> *Apart from our supported housing, I'd say as many as 10% have mental health problems.*
> *Director, RSL [78]*

> *Up to 50% in one area might need some support, because of the operation of re-housing policies, and the nature of the building (eg: high rise, single flats).*
> *Area Housing Manager, RSL [140]*

> *In bed-sitter areas, it can go up to 50%.*
> *Housing Officer, RSL [141]*

> *It's an impossible question – we all may need help at some time!*
> *Housing Manager, RSL [80]*

This divergence seems to reflect the breadth and imprecision of the concept of "mental health problems". Are we talking about "major league" issues - schizophrenia? Or does the concept include anxiety, depression, obsessive compulsive disorder, agoraphobia, hysteria, paranoia, personality disorders?

But the divergence of estimates and examples of those with mental health problems may also reflect the fact that people with major mental health problems do tend to be concentrated in certain parts of town, and even in certain properties or estates. The social housing staff who manage inner-city properties will also see a disproportionate number of individuals with major mental health (and other) problems.

Nevertheless, there also do appear to be some problems or syndromes that are particularly met by housing agencies and most often dealt with, in practice, by housing staff rather than mental health staff.

Examples suggested to us were:-

- hoarding, by tenants with obsessive compulsive disorders, becoming a health and safety hazard;
- paraphrenia – the conviction of persecution by one specified neighbour, often with noise or mysterious devices;
- general, low key inability to cope with "activities of daily living" (the last three of the HoNOS or Health of the Nation Outcomes Scores, which tend to be given a low priority either for referral or for case retention by mental health teams);
- problems of personality disorder, which until recently have been excluded by mental health services; and finally
- those areas of social inclusion requiring community work and integration, where mental health services are constrained by their own philosophy and ethics, particularly around confidentiality.

All these are areas of community mental health in practice where it seems that social housing staff may go where statutory mental health services do not go.

2.1.3: INTER-AGENCY UNDERSTANDING

Closely linked to a lack of recognition of housing's role in community mental health is a view that both housing and mental health services need a better understanding of each other's basic working processes. It was felt that better understanding would lead to smoother co-ordination, and the avoidance of the frustration of ill-informed and unrealistic expectations.

Staff wanted better understanding of the organisation of psychiatric services, the powers and limitations, the pressures and timescales and other constraints with which they work - and felt that mental health services needed similarly to understand theirs.

> *We need to understand how other directorates work, and what their priorities are.*
>
> *Lettings Manager, ALMO [16]*

> *We need training to appreciate their thresholds – to know what Health and Social Services can really offer.*
>
> *Homelessness Manager, LA Housing Dept [65]*

> *They have an ill-informed sense of what housing management actually needs to know about, just as they have no real sense of what we actually do*

Housing Officer, RSL [94]

I was involved with re-housing for a paranoid schizophrenic, and I was invited to case meetings, and I found them very helpful. I learnt a lot about what health and social services can and can't do. I found it very helpful to learn the boundaries, and be treated as a partner in the process.

Housing Officer, RSL [116]

Where housing staff are dealing with a complaint regarding an existing tenant, mental health staff may be quite unaware of the involvement, the options and the powers available to housing services, and the opportunity of working together to resolve problems that cannot be resolved in isolation.

The 1st case example, below, illustrates what can be achieved in working together. But see also the section following on "Co-working and confidence-building", especially the comments on the need for pro-active involvement.

CASE EXAMPLE 1 : JOHN

An example of successful joint-working between housing and mental health staff to resolve a problem with a tenant which neither agency could have resolved alone.

John is diagnosed with paranoid schizophrenia. He also drinks heavily – to relax - and sometimes to the point where he has blackouts; he is a smoker, and has at times dropped lighted cigarettes, or left pans on the gas cooker. He has good family support, but his largely nocturnal habits have brought him into conflict with his downstairs neighbour in the block of flats where he lives, who has been disturbed by John's "squirreling about" in the middle of the night.

The Housing Association, which owns and manages the flats are becoming concerned that his blackouts may present a health and safety risk both to himself and to others. There is a CPN involved, who has taken the view that there was little he could do, as he has no powers to intervene, and it is John's right to live the lifestyle he chooses.

The downstairs neighbour approaches John's brother, visiting one

day, with complaints about the night-time noise. The neighbour is not unsympathetic initially, but when he hears of John's blackouts, all the neighbours become alarmed, demanding of the HA worker that something has to be done, and threatening formal complaints and even legal action if the HA does not remove the problem.

The HA has no formal procedure or guidance for working with mental health services; but there is in the HA office an experienced worker, and after talking it over with her, the Housing Officer contacts the CPN. He explains to her that John's tenancy could be in jeopardy unless they between them can find a way forward. The CPN agrees to a joint visit.

When it is explained to John how his behaviour is unsettling others, and that he could face a possession order if he is unable to properly take care of the property, John is very concerned, but the two workers re-assure him that they are working to find a solution that works for everyone. The CPN arranges for a full assessment of John's capacity to live independently. This results in his getting a microwave, and some adapted cooking utensils; and a pair of slippers, for night-time wear.

Sometimes, it seems, the solutions may be as simple and as practical as a pair of slippers – once the agencies and the tenants/service users are able to communicate, to appreciate each other's concerns, and work together.

It was widely felt that there is a lack of appreciation by mental health service staff of the needs of, and the constraints upon, housing workers. This particularly applies to the need to gather sufficient information on individuals who may be homeless or at risk of homelessness, to determine whether they may be owed a duty under the homelessness legislation, and, if so, what accommodation would be suitable for them.

ALAN EDWARDS 13/12/05 15:14
Deleted: ing (within tight time limits, if they are making a

ALAN EDWARDS 13/12/05 15:15
Deleted: to determine

There is a strong wish, from most interviewees and almost all frontline staff, for better understanding of mental health issues, and a widespread demand for training. (This issue is discussed in more detail the following section.) Some staff have suggested it would be equally desirable to have some form of housing training for mental health workers. In the meantime, shadowing of housing staff for mental health workers has been suggested as a good way to develop relationships and understanding, build trust, and to facilitate future channels for sharing information. (See below, "Informal contacts and shadowing")

Some staff asked for information on all support services available; most wanted something specific on mental health, covering all the mental health team specialisms, and their catchment areas etc. Some areas have produced such directories, but the staff we saw were largely unaware of them, or have

limited access. They are perhaps not disseminated to housing staff. Still others have suggested there would be some value in a website – particularly for more specialist needs and "niche services".

Inter- agency understanding is clearly beginning to improve in some areas. Many authorities now have housing and community care strategy officers. Many will also be beginning to address such inter-agency communication and strategy issues via LITS and LSPs (local implementation teams, and local strategic partnerships).

But this tends to be happening only at more corporate or strategic levels. On the "frontline" mutual understanding is more often lacking – or is patchy, and overly dependent on relationships and building trust between individual workers.

2.1.4: TRAINING

Some housing staff do have (and almost all it seems would wish to have) some basic training in recognising mental health problems, which gives them greater understanding and the confidence to deal more sensitively with vulnerable tenants. Such training helps them identify when it is appropriate to seek extra help or advice. This we have identified as Mental Health *Awareness* Training.

Housing staff also wish to have information on how to access mental health services when concerned about a tenant, to pass on information, for advice, and also to check if a referral might be appropriate. They need to know what the process is. This we have termed Mental Health *Access* Training, to distinguish it from awareness training, which is primarily a matter of customer relations skills.

Mental health awareness training in some form was the commonest expressed wish of all interviewees. Of these, approx one third wanted a combination of both mental health awareness and access training, as a package. A few, however, suggested that, whilst all staff should have mental health awareness, only a smaller number, perhaps just a few in each office, needed more knowledge on accessing services. Teams with more specialist roles, however, such as homelessness services, may have greater need of this knowledge

It is of course likely to be more meaningful to have such access information and training, if there are locally agreed channels for information sharing, and referral mechanisms that are open to housing staff. (See below.)

Nevertheless, over half of those interviewed (76) identified some form of mental health awareness training as a wishlist priority for them. The Social

Exclusion Unit's report on Mental Health and Social Exclusion has also already recognised the need, concluding[xviii] that:

"ODPM will work with the Chartered Institute of Housing to ensure that mental health is fully reflected in mainstream education and training for housing professionals."

Meanwhile, it is important to note that some staff suggested that mental health workers receive little training to enable them to help them to resolve housing issues. Arguably, just as all housing staff might benefit from some degree of mental health awareness training, the same would seem to apply to mental health staff, although here, too, their levels of need might vary, with some needing more extensive knowledge, and then being able to act as an information resource to their colleagues.

It was suggested that joint, inter-agency, training on issues of mutual concern would also be very effective in establishing closer relations and mutual trust between workers in any one locality. This issue is explored in the next section.

2.2 WHAT WORKS: CO-WORKING AND CONFIDENCE BUILDING

2.2.1: PROTOCOLS AND CHANNELS FOR INFORMATION SHARING

Housing staff consistently reported difficulties in obtaining the information that they need, whether to assist in suitable lettings, or to manage problems on an estate, or to deal with arrears and complaints. The wish for protocols and/or channels for information-sharing between housing and mental health services was the second commonest of all stated priority wishes.

From area to area, there seems little general agreement or clarity on the kind of information that can and should be shared between housing and mental health staff, to assist in managing problems that threaten a tenancy.

> *There could be a lot more consistency in sharing information*
> *Homelessness and lettings officer, LA Housing Dept [47]*

> *Care and support providers need to be aware that we need information, so that we can know what lettings are appropriate. But there is also health and safety, the safety of other tenants.*
> *Supported housing manager, RSL [104]*

> *Risk assessments aren't shared, for example.*
> *Housing Officer, LA Housing Dept [52]*

> *There's also a lack of consistency between housing agencies over what information we do collect; that probably makes it harder for mental health staff, who then can't see why we do ask for information.*
> Lettings Officer, RSL [128]

There are examples of good, workable information-sharing protocols. They do nevertheless depend on a shared recognition of what things housing services may actually need to know. Yet housing workers often see mental health staff as actually mistrustful of housing staff, and very reluctant to give information.

> *The response is often "why do you want to know? What's it got to do with housing?"*
> *Snr Housing Manager, LA Housing Dept [39]*

> *Social workers will often give us "advocacy-filtered" information - only what they think it's good for us to know.*
> *Homelessness service manager, LA Housing Dept [5]*

The assumption is always that we're ringing with a complaint. That's when things go wrong. They think we think their client's the problem. But often, it can be the neighbours instead – the person is being harassed or victimised or exploited.

Lettings Officer, RSL [127]

The frequency with which this point was made must stand as evidence that it is at least not uncommon for mental health staff to withhold information from the local housing services which would enable an individual's vulnerability and eligibility for re-housing to be assessed. This applies even in the case of homeless hospital in-patients needing urgent re-housing, where it is clearly in the patient's immediate interests to have such information passed on.

Social Services are too anxious when nominating one of their clients that they might get "the bottom end of the market" if they are too open. They need to understand how properties are allocated. Supporting information should be sent in, just the same manner as you would about physical disability.

Housing Officer RSL [84]

Some agencies will not disclose information to you that we need, in order to establish whether we can take somebody on. It takes a lot of perseverance; and then you have to point out that we just can't pursue things any further without the info, and then they tend to realise that you're not trying to block housing somebody for mental health reasons; it's quite the opposite.

Housing Officer, RSL [106]

I had to cancel an application, because I got no information from the mental health teams, and I didn't know if they would get any support for their needs. But I had to consider the possible effect on others there.

Lettings Officer, RSL [93]

But we need to know enough about the problems, so we know how to place them so it will last – so they aren't made more vulnerable, due to estates management problems.

Allocations Officer, LA Housing Dept [148]

Pre-discharge information on an in-patient at least gives us time to find something more suitable than B&B or a homeless persons hostel

Homelessness Officer, LA Housing Service [45]

In some areas, Data Protection legislation is regarded as the main inhibition to information sharing. In others it was barely mentioned. This suggests that there are local service cultures that interpret this legislation more or less restrictively.

We used to have a fantastic relationship with Social Services. The biggest problem for us has been the Data Protection Act; it's created invisible barriers – people are frightened of sharing information now.

Housing Manager, LA Housing Dept [147]

Now, with DPA, we're not told anything, until they move in. But then it can take weeks, arranging for support services to start. If someone needs help, six or eight weeks can be a long time.

Supported Housing Officer, RSL [102]

But if it's about Data Protection, or if it's about medical confidentiality, either way, surely they could be a bit more pro-active about obtaining consent?

Housing Officer, LA Housing Dept [149]

In some areas, information-sharing protocols do exist; but they seem to be not well used or not well maintained. Frontline staff are frequently unaware of them. Protocols around communications between health and "social care" may leave it ambiguous as to whether housing staff are actually included. Issues of communications with housing services are not often specifically addressed.

It has been suggested that general inter-sector protocols have little real impact; and that it is only when agencies or even particular individuals are clearly identified as part of the information sharing group, that they are entrusted with essential communication.

NB: Where an individual, on behalf of their agency, attends a local inter-agency group, such as a Safer Cities forum, this usually comes with an accepted implication that any information shared should be treated as confidential to the individual attending.

However, this frustration at lack of information is not reserved exclusively for mental health services. In some cases, internal communications – such as between the Local Authority homelessness service and the area housing staff– fail, and there can be conflicts of interest and tensions between departments over information sharing.

We don't always get the information we need from Homelessness. That's just to assess if they are eligible for re-housing; so the information doesn't always get passed on to us, to help decide what housing would suit them.

Allocations Officer, ALMO [33]

We can always phone and ask the medical priority team, if there's any reason why this property isn't suitable. But still, their role is to get someone re-housed – they won't always look at the long term implications.

Lettings Officer, LA Housing Dept [152]

More Local Authority housing services are now moving towards Large Scale Voluntary Transfers or "LSVTs", and are creating Arms Length Management Organisations or "ALMOs". This involves separating their strategic housing responsibilities from the day-to-day management of the housing, which the new organisation undertakes. (In some cases this includes homelessness assessment service.)

The potential for conflict of interest between departments would appear to be greater between two formally separate agencies, where one agency – the local authority itself – has the statutory housing responsibilities to house, and another – the ALMO – manages the actual housing stock.

2.2.2: INFORMATION GATHERING

Where information is provided by mental health staff assisting with an application, lettings staff tend to respond with further informal discussions, creating a dialogue which is more likely to result in a suitable housing offer. Increasingly housing services are asking for such information as a standard part of their applications process. Where they do not (and many Local Authority services do not) such an approach was frequently felt to be valuable.

The new letting policy is more "in-depth", and now more transparent on how applications are assessed. As a result, people are more often referring to health needs, including mental health needs.

Allocations Officer, RSL [142]

A list of key contacts is kept in the office, and information on contacts is kept on the individual tenant's file.

Housing Officer, RSL [143]

There needs to be some procedure to ensure that information on a service user's needs is available at the local housing office. But maybe not to everyone there – maybe just to a few.

Medical re-housing officer, LA Housing Dept [71]

Getting info at sign up, before the tenancy starts, really works.
Housing Officer, ALMO [22]

In particular, housing workers wanted to ensure that any stigma from acknowledging the need for support should be removed as much as possible. References to available support, it was said, should be included in all information and application packs, and should be addressed as sensitively as possible in interviews.

If they don't want any support, we can still make it clear that support is available. I always make it clear that many people here do have support needs.
Warden with general needs housing attached; RSL [102]

We will raise support issues at the point where people apply, and when they sign up. Because it's in there from the start, it's more acceptable. Then we can make a closer assessment of people's needs.
Snr Housing Officer RSL [133]

CASE EXAMPLE 2 : SUFFIELD HOMES

An example of an agency which has introduced support needs assessments at the point where applicants sign for a tenancy; and retrospectively, with existing tenants.

Suffield is a district council in the Midlands, which had converted its warden-aided services to a peripatetic Care Co-ordinator service, in the late 1990s, and was subsequently able to expand this service, developing its own generic floating support service, available to all tenants. Suffield Homes, an ALMO since 2002, has retained the support service, as an in-house service offered to tenants.

For new tenants, on receipt of a housing application – whether via the local council's homelessness section, or via the Housing Register – a text note is added to the screen if the "case" seems to suggest the need for a support package. When considering allocating a property, the Neighbourhood Housing Officer can see the text notes, and considers the need for a referral to the Tenancy Support service.

The Housing Officer can then raise the possibility of extra support with the applicant. The staff believe that raising the issue at interview is the most suitable and most sensitive way. Nevertheless, there is also an information pack for new tenants, phrased and laid out in such a way as to indicate that there is no shame, blame or risk entailed in recognising the need for support.

There are leaflets on the service on display for all to see in the Housing Offices. There are also guidance notes, to help a tenant or applicant to identify their support needs; these notes can then lead on to drawing up, with the tenant, a support plan. Full details of the intentions and operation of the service are also contained in the induction pack for new staff.

(Existing tenants with support needs may therefore also be identified by the Housing Officers or District Housing Management; also by statutory bodies – Health and Social Services and Probation, and voluntary agencies; or by tenants' themselves requesting help.)

The support service is intended to offer low key support only; but the support staff are now more able to recognise the need for longer-term support, and have developed working links with more specialist support services operating in the area, for referral on.

2.2.3 TENANT-BASED INFORMATION SYSTEMS

Practical problems may evidently escalate through a simple failure to take remedial action in time. Of these, problems with benefits, leading to mounting rent arrears, can be the most worrying for the tenant. If the information systems can recognise that an individual getting into arrears has known mental health problems, then a support worker can be alerted and appropriate action taken, before the problem gets out of hand.

However, there is frequent discontent with the information systems used in housing services. These were often not seen as adequate to identify problems relating to individual vulnerable tenants, or to gather the information on housing needs necessary for a more strategic use of the housing stock

> *Our communications system isn't appropriate – it's a property-based system, not person-based. It can't flag up any particular sensitivities.*
> *Housing Officer, ALMO [27]*

It was suggested by some that housing service software systems need to be able to identify more easily those who are vulnerable in any way. People with a mental health problem should not just be identified where there is a potential health and safety risk to staff. In housing staff's account of how they might first identify individuals as having possible mental health problems, self-neglect, complaints (whether by or about a tenant) and failure to maintain the property figured far more often than problems with rent arrears.

It was therefore suggested, for example, that if information systems could identify those who might be vulnerable or at risk of social exclusion, it would be possible to intercept standard letters that might be confusing, or appear officious or threatening. Such messages could be re-directed perhaps to designated care and support staff, and/or to appropriate housing staff who have knowledge of that particular individual's needs.

Preliminary soundings with two local area mental health service user support groups indicate that, with the right safeguards, this might be welcomed by many, but not all, tenants with mental health problems.

Such an information service could certainly not – except perhaps in very exceptional circumstances – be imposed on an individual without the tenant's consent. But it could be offered, as an additional service - as a peace-of-mind guarantee.

If so, there also needs to be a guarantee that the information on the individual's needs is kept within a tight confidentiality boundary, and is not available to all on the computer network. It should be possible to maintain levels of confidentiality on a "need to know" basis.

Where housing services have identified a linkworker (see below), that person would be the obvious candidate for sensitive information. Such an arrangement again suggests the advantage of having a worker-centred, rather than general or agency-based confidentiality/ information-sharing agreement.

Early identification of problems could be used simply to flag up concerns, to be addressed internally, or to trigger a referral to support services. Such low key and practical support needs would be most unlikely to trigger a formal mental health team referral. Very often, at this stage a generic support service will be the one most appropriate, most acceptable to the tenant.

To enable support services to intervene at a point before intensive services are not needed, it is important that mental health support services can accept referrals directly from housing agencies, without the need for prior prioritisation by CMHTs.

Where, even so, Supporting People funded services are not available, intervention by housing staff remains, as before, the default (see below, "Support services"). It has been suggested for example that more time and attention to such issues at an early point may actually save housing management time in the long run.

This would again suggest that creating linkworker roles (see below) within housing services would be valuable, whether or not there are also more specialist housing-related support services available.

2.2.4: CO-WORKING AND PRO-ACTIVE INVOLVEMENT

A wish for more joint-working between housing and mental health staff in resolving difficulties for tenants, was, alongside the development of linkworkers within housing services (see below, 2.2.6), the joint fourth commonest wish expressed, and the joint third highest identified as top priority.

Although the great majority of housing staff interviewed have expressed some degree of frustration alongside a desire for better communications and closer co-working with statutory mental health services, there were nevertheless others who reported good relations.

> *We had a tenant who is illiterate. But we didn't know that until we spoke to the support worker. Now there's good joint working, and we don't send letters – we visit.*
> *Housing Officer, RSL [119]*

> *They're generally pretty good. We've got good contacts now with …… House (mental health team base).*
> Housing Officer, LA Housing Dept. [44]

> *I can't fault them (mental health services); they've been brilliant –they'll always come straight way when I need anything.*
> *Warden, sheltered accommodation, RSL [131]*

There were however many more comments on the difficulty in engaging mental health services in joint working, or even of getting advice on what a tenant may need or be anxious about.

> *I have to justify my concerns. I'm wanting advice, information, joint work, but they seem reluctant, guarded.*
> *Housing Officer, RSL [98]*

> *Mental health services don't want to get involved with housing. We give the person the tenancy, and that's it, goodbye. We have to deal with any anti-social behaviour without any support. The CPN with the substance abuse team was very good, but it was "three strikes, and you're out". They all drop out like that, and we have to pick up the pieces.*
> *Housing Officer, RSL [114]*

> *We have to handle the situation. The only way we can handle the situation is if we are included in, or knowledgeable of, the care and support plan. And the plan also has to be feasible, from a housing management point of view.*
> *Area Housing manager, RSL [117]*

You get the attitude – "Well, what do you expect us to do?" . Well, at least we want some advice, some information, maybe help, to see if there's anything more we could do.

Snr Area Manager, RSL [123]

Housing staff frequently expressed the wish that mental health staff should be involved at an earlier stage in problems that can lead to the loss of a tenancy.

Things have to reach a crisis stage before problems are taken seriously by mental health teams.

Housing Officer, RSL [//]

The problem was always the slow response from the statutory agencies

Lettings Officer RSL [141]

But you get " I haven't seen her for two months, she's never in when I call…" But that's not a reason to be un-concerned. Why not talk to us?

Housing Officer, RSL [127]

It's only when we are in court for high arrears that the CMHT worker comes out of the woodwork.

Lettings Officer, RSL [99]

At its worst, housing staff talked of needing to invoke tenancy termination, in order to "flush out" any mental health service care or support staff involved with a tenant. This is NOT seen as good practice; but good practice requires inter-agency co-operation.

Getting information from mental health staff, it's about getting a working relationship, so that we can help. But I just got a brick wall. It was only after I got shirty, and started talking about the bottom line being eviction, that the CPN opened up and started talking to me.

Housing Officer, RSL [103]

The "possession route" has had to be used in some cases, just to get SSD involved

Housing Services Manager, RSL [140]

When we need help, they just say they can't help. They can't even see a role for themselves in helping. Even when it goes to tenancy enforcement and eviction, they still don't see that they have role in this. Often there is simply no communication. Things go wrong, it goes down the road to enforcement, and only then there's a case conference; and we tend to sit there and think, "Well, where have you been?".

Area Housing Manager, ALMO [20]

However, where housing officers and mental health workers have worked together in the past, and come to understand and trust each other, earlier intervention is more likely to occur to resolve issues before they reach crisis point.

In some areas, the new Assertive Outreach teams in mental health services are also explicitly exempted from concerns about excessive reluctance to share information with housing staff. Similarly, where there are mental health staff, or even whole teams, that work specifically with homeless people, relations and communications tend to be far more positive. There are markedly fewer complaints about housing support services' in-put. In this context workers tend to more readily involve housing colleagues.

Other than (or prior to) the growth of Assertive Outreach teams, better relations have often been a by-product of local circumstances that have brought workers together. Typically the difficulties of one tenant have been the catalyst. This may often lead to a growth in trust and a better foundation for future involvement in other cases. Sometimes better inter-agency relations develop informally, simply because organisations have offices in close proximity to each other.

Joint work is seen as good practice when it happens, but it appears to be the exception, rather than the rule. Contacts tend to be ad hoc, idiosyncratic, unpredictable, and unreliable. They are dependent on individuals, and can be un-done when either a worker leaves, or when re-structuring changes the organisational boundaries.

More structured approaches, however, may have some value: this issue is addressed in the section on "Informal contacts and shadowing".

Nevertheless, perhaps the key to understanding the unique role of housing management in community care is to realise that housing staff will often be responsible for an entire block, estate or even neighbourhood. They must therefore balance their responsibilities towards individual tenants with their responsibilities to the broader community of tenants.

> *Meanwhile all the neighbours are coming to us, expecting us to do something about it.*
>
> *Warden, RSL [102]*

> *Our job is to manage the whole situation, on behalf of all those who live there.*
>
> *Area Housing Manager, ALMO [24]*

Because I talk to all the neighbours, I get a better picture of the problem than the CPN, who only talks to her. But the tenants are there all day, all week,

Warden, integrated care complex, RSL [120]

We are the statutory agency that's out there, in the community; all the complaints come to us first, and we have to decide what to do, where to go.

Area Housing Manager, ALMO [24]

Despite, or perhaps because of, this divergence in responsibilities and perspective, housing staff often wish to have greater involvement with mental health workers.

We know our community; but we're not the experts here; we don't have the training. We need the experts to come out with us.

Housing Officer, specialist BME RSL [132]

It's amazing how much they don't know about their clients – sometimes really horrendous experiences, which either they don't or won't share with the worker, or if they do, the worker isn't sure whether to believe them.

Lettings Officer, RSL [127]

We can't be experts in all areas. But our job is to facilitate help

Development Manager, RSL [129]

How much easier it would make their work, if they worked with us.

Housing Officer, ALMO, [22]

All too often, it seems, mental health teams may see this broader community involvement as compromising, or as quite incompatible with, a legitimate role in community mental health.

Where mental health services have focussed increasingly on individual casework, with the CPA (see Glossary) as the key to sound practice, housing management must inevitably engage with the wider community. In many respects housing management now deals with community work and social inclusion issues which mental health services do not.

2.2.5: REFERRAL AND ADVICE

Housing staff may often receive information which gives cause for concern on tenants who are not known to local mental health services, or whose case is now closed. Concern over information-sharing was frequently linked to the issue of referrals. A repeated request was for guidelines on how to make referrals, and, in some areas, for it to be accepted that housing staff can make referrals at all.

There seems to be little consistency between areas, or even between different offices, as to whether mental health services will accept a request for CMHT involvement (even with the consent of the tenant) or whether all such requests must necessarily come via a GP.

> *We need clear, workable pathways for referral*
> *Homelessness service manager, LA Housing Dept 65]*

> *We get "don't see how I can get involved unless he wants to come and see me" from the GP. But in the meantime, we're the ones getting the complaints, we're the ones dealing with the situation, on our own*
> *Snr Housing Officer, LA Housing Dept. [155]*

> *I was told I had to make the referral via the GP. I insisted that he just wouldn't do that. In the end, they took the referral; but I was made to feel that this wasn't the proper way to do things*
> *Housing Officer, RSL [98]*

> *I'd like set procedures with guidelines – who to contact.*
> *Housing Officer ALMO [28]*

Several staff interviewed complained that they do not know when a case is closed to mental health team in-put, so it is particularly difficult for them to judge if a problem is being managed, of if they should be making a new referral.

> *They should keep us informed of support packages. Just so long as we know it's being dealt with, then all we need to do is keep an eye out, from the sidelines. But we need to know, if something goes wrong, who to contact.*
> *Housing Officer, RSL [102]*

> *But we need to know that something is being done, just to put workers' minds at ease that they have discharged their responsibilities, and also so that they are able to play a constructive role in sorting out the problems, if needed.*
> *Vulnerable adults service manager, LA Housing Dept [65]*

We'd actually had a good relationship with the social worker who had placed him here. But then it turned out the original social worker had left; and nobody told us.
Area Housing Manager, ALMO, [20]

Confidentiality constraints do mean that (notwithstanding any inter-agency information-sharing protocols that may be in place) there will inevitably be times when certain information still cannot be divulged to housing staff.

In that situation, housing staff passing on information and raising concerns need at least to be confident that the information has been received, and a decision on appropriate action has been made.

In the absence of any agreed "exit plan" identifying who to contact in what circumstances, there needs to be a process by which housing staff can alert mental health services, and make a referral in their own right, if need be, with the consent of the tenant. Where the tenant will not consent, housing staff may still need advice on what is appropriate or useful.

2.2.6: OTHER STRUCTURES THAT FACILITATE JOINT WORK

- **Linkworkers within each housing agency**

A wish for the development of linkworkers within housing services, was the joint fourth commonest wish expressed, alongside more and closer joint-working between housing and mental health staff in resolving difficulties for tenants; and this was the joint third highest identified as a top priority.

Some housing organisations have already identified one or more workers who can operate as linkworkers with mental health services, developing contacts and knowledge of support services and how mental health services operate. Others have suggested that this would be particularly valuable. In at least one instance a person with a mental health service background had been deliberately recruited for this role.

We need a dedicated worker to handle the casework side – establishing a care and support package that fits, doing the networking, with the authority to say, "okay, that will work", or "okay, that's the best that can be done."
Housing Officer, ALMO [11]

We need a specialist worker, in-house, someone you can run things by…… I mean, we have a first aid worker. Why not have someone who knows about mental health?
Housing Officer, ALMO [34]

In this office, no-one has any particular role or caseload. It feels like we're muddling through with common-sense. Perhaps we could do with one semi-specialist worker – or maybe not in this actual office, but in the area?.
Housing Officer, RSL [105]

We need a link person, or a direct contact process otherwise, with the hospital, around discharges. When we had [joint funded worker] around, he was brilliant
Homelessness Officer, LA Housing Dept [6]

There are a number of examples of linkworkers within housing services and within mental health services – although it seems that this practice is most developed in homelessness services, where the need to assess and address mental health vulnerability, and consequent eligibility for re-housing, arises more frequently.

These linkworkers are able to provide advice and guidance to other staff who are less knowledgeable, and may often take on the cases/tenants who present with more complex problems. In some cases, workers from a floating support service attached or closely aligned with the general needs housing service may play this role, rather than a worker from within the housing service itself.

- **"One-Stop Shop" contact point for advice and referral**

Another frequent concern of housing officers trying to contact mental health team staff was that it can take a very long time (and many fruitless calls) to identify which mental health workers, or even which team, is involved.

Many housing staff therefore suggested the need for an advice and referral *service,* which can be accessed by staff with concerns about a tenant. It was proposed that this should be one contact point, for advice (including whether, and how, to make a more formal referral) – or just for information sharing, with the assurance that information will be passed on to the relevant worker

This idea – "the equivalent of NHS direct" - was termed a "One Stop Shop" for advice and referrals. This idea came seventh overall in the wishlist of practical suggestions for changes that would make for real improvements.

There's no central point for information – somewhere where, if they don't know the answer, they will find out and get back to you. We set up something like this where I used to work before, at the hospital. That's what we need here.
Community Assistant, RSL [121]

You can get through if you can get a name.
Lettings Officer, ALMO [11]

I had to hunt round through Yellow Pages to find the local address.
Snr Housing Officer, RSL [133]

A "One Stop Shop" would be more centralised and organised than either a referral procedure, or a linkworker role, and more accessible than a directory of services. But it would need resourcing, and hence may only be viable in larger areas, or if shared across all community care client groups (see below, "Good practice on the ground").

Nevertheless, there are some examples in other areas of such services, run by voluntary agencies, with premises made available by the local Mental Health Trust. In other areas, also, there have been "clearing house" arrangements for care services for the elderly, which offer a parallel model.

- **Informal contacts and shadowing**

As we have seen, the inter-agency communications atmosphere evidently changes radically, where mental health and housing staff actually know each other – typically through having worked together in the past to resolve a problem with another tenant.

Where we have been working in an area a long time, the links tend to be better.
Area Manager, RSL [140]

Where formal communication channels between housing and mental health services do not exist, informal relationships of trust between workers of each agency in one locality may nevertheless sometimes develop. It seems, for example, that CPNs or specialist services working with homeless people often develop better links with local direct access hostels and the homelessness sections of housing departments.

But there is too much reliance on individuals, and them talking together. There should be a more structured approach.
Snr Housing Officer, RSL [139]

Some housing staff therefore suggested that new staff during induction should "shadow" a worker from another service for a day or more, developing knowledge and contacts that will be valuable for later working relations. Several workers gave examples of shadowing staff of other agencies as part of their induction. This is always spoken of as something very positive.

The importance of this sort of approach of shadowing within a related organisation has long been accepted by the Chartered Institute of Housing for students undertaking its Professional Qualification. Mental Health services could be specifically identified as an appropriate area for such temporary placements.

This is an expensive use of staff time, but could clearly be justifiable where there is the expectation of on-going contact between agencies – such as in homelessness services, shadowing a new CPN for the homeless - or where there is the intention to develop a linkworker role.

For housing staff to spend a day with mental health staff, a confidentiality protocol needs to be in place. Protocols that allow greater involvement to designated housing staff (see Linkworkers above) are more flexible in this respect than those that apply to the organisation as a whole (see earlier, 2.2.1)

Improved relationships between individuals, however, valuable though they undoubtedly are, are no real substitute for agreed, systematic communication channels and protocols for all staff.

- **Local area forum for sharing issues**

Many suggested – sometimes as a more informal alternative to an organised service, such as a One-Stop Shop - the need for a local inter-agency forum. This can provide an opportunity for local area staff to meet and to get to know each other. It can develop the informal relationships that seem in practice to under-pin better communications. This suggestion came eighth in the wishlist of ideas as to what was most needed in particular localities.

Various examples of local forums and suggestions were put forward where housing staff and local mental health team staff can meet, develop working relations and understanding. Some suggested simple informal lunches between locally based staff with an interest in community care and joint work. Others suggested more formal inter-agency meetings at which particular problematic cases might be raised subject to confidentiality protocols.

> *There was a voluntary sector housing forum in my previous area; this would help here in promoting partnership working.*
> *SM, LA Housing Dept [138]*

> *There is close and effective joint working in (nearby area) through a referrals panel*
> *Area Manager, RSL [140]*

There were several examples of forums, past, and present and just developing, where local mental health and housing staff can meet to discuss common issues. In every case they were greatly appreciated. (NB: In areas outside this study, such a forum has developed further into a referral mechanism for aftercare and supported housing; or led to full integrated commissioning[xix].)

Such a variety of suggestions indicates that there is value in the practice. However, it also indicates that the precise nature of the forum may need to be responsive to the particular local configuration of services. Local forums could for example be generic – for all working in the community in one small area - or could be specialist – all with an interest in mental health and housing meeting regularly. Preferences were expressed for each of these models; each was seen as valuable. The nature of the forum needs to make sense in and for the local area.

We return to this issue of "best fit practice " in the final section, on "Inter-agency practice and local context".

- **Re-structurings**

There were a number of examples of offices of housing and mental health services being located near to each other. There was a general feeling that this assists in developing good working relationships.

When Social Services was generic, their boundaries were co-terminous with ours, and we often shared buildings, or we were on the same street. You could go for a chat. They wouldn't go into detail, but they could indicate if there was some support going in, and they would often indicate who to go to; or pass on a message.

Area Housing Manager, ALMO [20]

We used to have the Adult Care social workers in the same office. They could give you advice, informally. They didn't even need a diagnosis before they could get involved.

Housing co-ordinator, ALMO [26]

We could be sharing premises with the mental health team.

Housing Officer, LA Housing Dept. [57]

In (another local authority area) they have a mental health clinic in a shopping precinct which boundaries onto our estate. That works very well, both for unofficial advice and then for proper referrals if need be. You can get a dialogue, issues get resolved.

Snr Area Manager, Specialist RSL [127]

Other suggested structures to encourage understanding and joint-working between housing and mental health services therefore included restructuring the housing services themselves.

In one area, after separating off housing stock management to an ALMO, the whole homelessness assessments and placement section was integrated into the Social Services Dept (together with Supporting People). In another, it was suggested by some that the medical priority assessment service could be operated independently, and so become a key bridge between housing and social care services. In several areas, staff suggested that sharing premises with local housing and health or social care services would be positive.

Interestingly, generic or "patch" housing services which are now developing specialist roles (or "functional" organisation) thought that this change would help to improve communications with external specialist services, such as mental health teams. On the other hand, functionally structured services now moving to a generic/patch model thought that this would help, as they would have a more comprehensive knowledge of the individual, through managing all aspects of the lettings/allocations/management process.

All organisational change can generate expectations and opportunities for cultural change. The key message from the views expressed is that every restructuring should be seen as an opportunity to put these broader inter-agency communication links back onto the agenda.

In the past, restructuring with a "service mono-culture" vision of efficiency have tended to ignore such external issues, and to break up valuable contacts – but at a real hidden cost, in loss of joint work.

- **Supporting People and floating support *s*ervices**

Of all the questions we asked, the question over the contribution of the Supporting People (SP) initiative elicited the widest divergence of responses, from those who thought SP "is brilliant" to those who said it had made no difference at all, and even those who said it had made things worse.

For some staff, Supporting People was equated with the development of floating support services in their area. Many argued that such support makes a very positive difference.

> *We are happier granting a tenancy now people can access support. It's changed very much the way the association works. We take on people who 4-5 years ago we would have refused.*
> *Snr Housing Officer, RSL [133]*

It's definitely dropped the stigma from needing support; and people are more willing to take on tenants than before

Housing Officer, RSL [135]

If people have a past, with problems like arrears, or noise, we'd like some sort of evidence that they've accepted and used support since.

Allocations Officer, RSL [128]

There is some movement from supported housing to mainstream housing with a floating support package. But more applicants could be housed in mainstream housing if more floating support was available.

Allocations Officer, RSL [142]

Then we can stand back, let them just live their lives, with support in place.

Warden, sheltered scheme with general needs cluster [102]

Others were rather less impressed. There were some comments that some support services seem inflexible in the way they are now contracted. One housing worker was sufficiently disenchanted with the quality of new support services locally, that he made quality control of support staff one of his three wishes.

They should vet staff more closely; they're not very practical.

Area Estates Manager, RSL [94]

I do have some concerns about the commonsense of some support workers, who hadn't flagged up concerns early enough.

Housing Officer, LA Housing Dept [49]

Floating support is fantastic, if the need is properly assessed, properly resourced, and there are good communication links. It comes down though, in the end, to the quality of staff on both sides.

Area Housing manager, RSL [140]

There were many comments that there is simply not enough housing support; and it was suggested that people who need more intensive and containing boundaries are sometimes placed prematurely in ordinary housing, simply for want of more appropriate supported accommodation.

It was his visitors who were taking advantage of him. He couldn't control their behaviour, couldn't set any boundaries. They were doing a lot of damage. In the end, his social worker got him a place in supported accommodation.

Community Assistant, RSL [121]

Some thought that one weakness of floating support is that acceptance of support is voluntary. They suggested that very chaotic individuals, those most at risk of defaulting on support plans, those with substance abuse problems, or a tendency to discontinue prescribed medication may not be best served by refusable support. But this has also produced some creative interplays of support and housing management.

In one area, an inventive approach has been developed, re-integrating floating support with intensive housing management, to meet the needs of more chaotic individuals in ordinary housing.

CASE EXAMPLE 3. SDHA's MAUNDY PROJECT

Shethernley is a unitary authority in the North Midlands, in an area of declining manufacturing industry. Much of the housing stock is old, and includes some high-rise and low demand (or "hard to let") properties. These tend to be inhabited by those placed there by the housing department, homeless people statutorily re-housed on the grounds of vulnerability.

Shethernley has identified a lack of appropriate supported and semi-supported accommodation for individuals with mental health problems. What supported accommodation there is, is in high demand, and in constant danger of "silting up", particularly as move-on accommodation with support is also in short supply.

As a result, individuals with mental health problems/in-patients at the local psychiatric unit, though stabilised in treatment, may often have to wait many weeks before a suitable place is found, and many are discharged into un-supported accommodation, and/or accommodation with visiting (or "floating") support that is insufficient to meet their needs.

But Shethernley and District Housing Association (SDHA) has developed an arrangement that seeks to maximise the impact of support available, and bring together more focussed support, in ordinary (or "general needs") housing .

SDHA have an agreement to take on, from other housing providers, a number of properties, which SDHA will then manage on behalf of the housing agency. These are decorated and fitted out with furniture by SDHA, even in advance of the service user moving in – or with them, as they are waiting to take up a place.

The service user takes the property initially on a shorthold tenancy or licence agreement basis, and if the placement is successful, after a period the property is returned to the original housing provider, and the licence converted into a full tenancy.

This arrangement allows SDHA to work with individuals most at risk of relapsing into dysfunctional behaviour patterns, whether substance abuse, petty crime and other anti-social behaviour, or erratic use of medication leading to repeated breakdown. It allows ordinary housing services, with no in-house support service, to let property to people they would otherwise be reluctant to house.

There do appear to be other examples of this practice evolving, quite independently, with some of the more "at risk" service user groups, in other parts of the UK. This is perhaps an approach that would merit a more thorough, more evaluative study for the future.

- **"Generic" floating support services**

There is a general welcome for "generic" support services – those that are not specific to any client group. Housing organisations found these the most accessible and free from stigma. Generic services are seen as willing to take people with or without a clearly identified mental health problem, and therefore will support those who are reluctant to see themselves as having a mental health problem.

Housing staff, who may not feel competent to identify exactly why someone needs help, can refer them to generic support services which will often have better capacity both to engage and to assess – 'a kind of triage'.

> *It's partly because we have our own in-house support service, which is generic. But we have also made good links with others – mainly in fact through them. They get to know the other services. But now we know enough ourselves about what they do to be able to know when to refer someone ourselves.*
>
> *Housing services manager, RSL[133]*

However, referral log-jams in specialist services – combined, perhaps, with user choice - may mean that sometimes generic services are struggling.

Generic services don't move people on to specialist services enough. They may be holding onto people too long, trying to deal with mental health needs. That could be okay so long as they have CMHT back-up, but they don't always.

Housing services manager, ALMO [16]

It has been suggested that generic support services funded by Supporting People, and floating support in particular, have difficulty demonstrating their "strategic relevance". These observations from housing staff may indicate that the greatest relevance for generic support lies in the area of social inclusion practice, under-developed though this area may be as yet in formal mental health provision.

Where support services are provided 'in-house', by the housing agency, (as in case example 2) this arrangement seems particularly popular. Where housing management and support staff are in the same office premises, support staff are then used as the most effective contact point for advice. In this way, they may operate in effect as "linkworkers" for the housing staff.

Having an in-house support team helps build up a rapport between the housing staff and the support staff; it also allows each of us to keep "in role" more – and helps to keep to other boundaries, like confidentiality.

ASB Officer, RSL [126]

It's hard to get through to mental health teams. But we can talk to our support colleagues, and they DO have those links. We're very fortunate.

Area Housing Manager, RSL [88]

Where there is no support service locally - either not in the area, or not in the organisation – some staff felt that it would be good to develop their own. A lack of new SP funding to develop this did not inhibit many from suggesting it. Some in fact suggested that developing in-house support would pay for itself in the long run, by employing workers with the responsibility to develop knowledge, skills, and contacts with other agencies and resources.

Now we've identified what support needs are, we still have to meet those needs, if the support services aren't there. We are back to treating it as intensive housing management.

Lettings Manager, LA Housing Dept [16]

Housing Management remains the backstop of community care

Area Housing Manager, ALMO [20]

There appear to be numerous examples of support needs "reverting to housing management", whether funded from the organisation's own resources, as intensive housing management, or in the name of homelessness prevention, or through neighbourhood renewal funds.

Where SP funded services have not been developed, many problems of tenancy sustainment, it seems, simply default back to housing management staff – or to more intensive mental health team involvement.

The wide range of responses of interviewees to the value of support services may itself reflect the inconsistent coverage of mental health support services nation-wide. But perhaps the best measure of the value of support services is that so many interviewees said that the main problem was that there is simply not enough.

(NB: The proposed Supporting People initial national strategy, currently under consultation[xx] would seem to endorse the option of expanding the SP "pot" from other sources, according to local needs and priorities.)

Others doubted whether there would be the resources, or the need, locally to develop more specialist support posts. Rather, they saw value in identifying one or more workers who can develop more knowledge of mental health issues and services, *within* housing services (see linkworkers, above).

- **Warden-assisted ("sheltered") accommodation**

We interviewed a small number (6) of wardens who manage sheltered accommodation, designed mainly for older people or those with disabilities. We also saw some housing officers and middle managers who manage sheltered accommodation staff within their area, alongside general needs housing. The logic behind this was that, as wardens were not mental health specialists, they might encounter much the same problems as general needs housing staff in responding to the mental health needs in their tenants, when providing accommodation to individuals with significant mental health problems.

This hypothesis was largely borne out. Wardens are also typically seen initially as "outside the confidentiality loop". However, this is mitigated by the phenomenon noted earlier, whereby certain staff eventually get to know and develop a closer working relationship with particular local mental health workers. This seems to occur more readily in sheltered accommodation, due simply to the concentration there of vulnerable tenants with care needs.

Some sheltered housing wardens were quite positive about housing people with mental health problems – some very much so.

I have about 50% tenants with major mental health problems – schizophrenia, manic depression, agoraphobia. Then dementia as well, of course. I would have 100% mental health if I could.

Senior support officer, RSL sheltered accommodation, [136]

Others had found the greatest difficulty lay in a lack of acceptance by other residents of someone who was "different". There is clearly an art to managing such integration, and it is perhaps better achieved through a pre-planned strategy than as a hurried ad hoc response to an individual housing crisis.

Some strategy and other managerial staff suggested that under-used warden-aided accommodation might be transferred to mental health services to manage, to develop a supported accommodation model. We heard of several such schemes. However, as such specialist mental health accommodation falls outside the scope of the study, we cannot comment further at this stage on the success of this approach.

There may be a debate to be had over whether such accommodation, which is by nature segregated, can be truly socially inclusive. Yet for those who need protection and company, sheltered accommodation may be a welcome alternative to residential care. Until there is such provision, ands until service users themselves can have the choice, we will not know if this is an option that they would wish to have available.

There is currently work being done elsewhere by the Dept of Health to identify issues and good practice in mental health and "extra care" housing for older persons, which will include the mental health needs of individuals in sheltered accommodation.

This work, when completed, will be included, along with other related issues on housing and mental health, on the website of NIMHE's partner in CSIP, the Integrated Care Network (http://www.integratedcarenetwork.gov.uk/).

2.3 HOUSING POLICY ISSUES

2.3.1: DISCRETION AND SENSITIVITY IN ALLOCATIONS

There has been extensive discussion over many years within housing circles over how best to manage housing as a scarce resource, how to avoid discrimination against marginalized or less "popular" tenants or populations, how to use maximum sensitivity to the needs of individuals, and how to use housing to assist in building or re-building a sense of community and empowerment for tenants.

Many staff have talked about the importance of sensitivity and discretion in allocating particular properties to individuals who are known to be vulnerable.

> *Our job is to produce sustainable communities. With every letting, you have to look at who's next door.*
> *Housing Officer, LA Housing Dept [141]*

> *But we need to know enough about the problems, so we know how to place them so it will last – so they aren't made more vulnerable, due to estates management problems.*
> *Allocations Officer, LA Housing Dept [148]*

> *I don't decide the suitability of a property - I will leave that to the person who knows best – the CPN or social worker – when something comes up, I'll phone them and we'll talk it over.*
> *Letting officer, RSL [108]*

> *There seems to be an assumption from mental health staff that we will treat people worse; but actually, we will treat them with more consideration, more sensitivity.*
> *Housing Officer, ALMO [12]*

Some however expressed concern that the discretion that housing staff used to have, to manage allocations sensitively, has been eroded by procedures emphasising equity in allocations over local knowledge of what may be suitable

> *If you simply "compute" allocations, you're setting everybody up for failure – you mustn't lose that local knowledge and local sensitivity. We couldn't achieve the quality of life for tenants if we didn't take such care over lettings.*
> *Regional Manager, RSL [122]*

But to use any discretion or sensitivity, housing practitioners would need to have the information in the first place, whether from mental health services, or via their own information gathering at the start of a tenancy.

Social workers seem to fear that we will reject or be prejudiced against someone with mental health problems; but it's not so. We need to know, so that we can help in our way.

Housing Officer, ALMO [13]

Medical priority assessment and re-housing is generally a more closely involved, more intensive and more sensitive process, partly because it is not always subject to such strict targets and deadlines as are required for homelessness assessment. But medical priority services vary widely in their level of resourcing within Local Authorities, where they are located and how they are integrated into other needs assessment processes.

In some authorities there is little "join" between medical priority assessments and assessments to determine whether a duty may be owed under the homelessness legislation. Medical priority assessments are often seen as belonging within the housing management side of the service. Hence they are separated from assessments of vulnerability to determine whether they have a priority need for accommodation under the homelessness legislation. Within RSLs, lettings officers deal with medical priority as one of many considerations, usually with carefully codified and balanced procedures for determining priority for allocation.

2.3.2: SUSTAINABLE COMMUNITIES

We have noted earlier the fact that housing staff will work with tenants in a community context, rather than via individual-focussed casework. The question of the discretion available to staff in allocation of particular properties was therefore tied in with many observations on housing's role in neighbourhood renewal, and in the building of sustainable communities.

Our job is to sustain a community in which people with mental health problems can live in their own homes

Asst regional manager, special needs RSL [122]

Some recent studies[xxi] have suggested that it is not primarily the quality of the housing stock, but rather the quality of the social environment, the extent of "social capital", that determines both the reputation of an area, and the peace of mind of residents. Many of the housing staff whom we interviewed saw the task of building communities as one of their most important roles. Work with local Tenants and Residents' Associations ("TARAs") was seen by some as a way of developing more tolerant and more robust communities.

The spotlight was brought on the issue by the residents association of the scheme.

Area Housing Manager, RSL [140]

We need to change people's perceptions of mental health. We could be using TARAs to help educate people generally in mental health awareness.

Tenants Services Officer, RSL [145]

It's still down to the neighbours being aware, looking out for each other. We are the ones who do the care in the community.

Federation of Tenants and Residents Associations [124]

The break up of traditional communities round here has hit those on the margins hardest – those most at risk of being excluded. They stand out more now.

Community Assistant, specialist RSL[138]

Some suggested that the issue of social capital is particularly critical for those most at risk of marginalisation, such as those with severe mental health problems. Positive discrimination could therefore consist, not only in avoiding the "ghetto-isation" of those with mental health problems, but in re-housing, with community support opportunities in mind. If Government policies are to help sustain rounded and tolerant communities, then housing and housing allocations policies, alongside tenants associations, have a key part to play.

We knew they'd been friends. So when he moved back to the area, we moved them both, to be near each other.

Housing Officer, RSL [128]

The mentally ill, they are a more transient group, they seem to find it harder to establish roots. We need more schemes with more focussed social support.

Housing Officer, RSL [135]

We need to look at the best use of our housing stock….. We have accommodation that could be used to support individuals who need company – we could develop a model like the KeyRing schemes for people with learning difficulties.

Strategy Manager, ALMO [11]

The focus of much recent attention has been on confronting anti-social behaviour. But some housing staff were concerned that it can be hard to distinguish anti-social behaviour from mental health problems. They were particularly keen to attract mental health service involvement at an early stage, to prevent eventual eviction when some other resolution can be found. But, as described earlier, they reported difficulty engaging mental health services when they – the mental health staff - cannot see what they could do if the tenant refuses mental health service help or referral.

We've got our powers, as housing management, for ASBOs, and eviction. But we need to use our authority as constructively as possible.

Housing officer, LA Housing Dept [12]

The increased emphasis on anti-social behaviour has raised the profile of mental health as an issue.

Housing Officer, RSL[142]

Whereas, if I call a case conference about anti-social behaviour, I have no expectations that anyone from Health or Social Services will come

Director of Housing Management, RSL [[86]

When I first came into social housing, I thought people with problems should be supported. The social element is important; and we are moving away from that. Now there is some political pressure, and we charge headlong down the enforcement path.

Lettings Officer, RSL [101]

More work will need to be done to identify "best fit" practice (see final section) in the ways in which the responsibilities of local authorities in community care can be reconciled with a response to anti-social behaviour. It is important to see both as equally central aspects of housing's role in neighbourhood renewal, that have to be balanced.

We will return to this issue, to consider some of the institutional mechanisms that need to be in place to encourage good practice, in the section on "Monitoring and Audit".

2.3.3: "CHOICE-BASED" LETTINGS

In an imperfect world, when people have choices, they tend to be more reconciled and satisfied with a choice that they themselves have made, rather than one made on their behalf. Early indications are that the "choice-based lettings " (or CBL) initiative of the last four years has had a significant impact on tenancy retention. We found considerable enthusiasm and confidence in the approach from staff closely involved with CBL. It is perceived to be good practice by those closest to it.

People make better choices in the first place (ie: when they make the choices themselves)

Allocations officer, ALMO [18]

The success of Choice Based Lettings is being monitored elsewhere. Our concern was simply to enquire whether housing staff in those areas where some form of CBL now operates have felt that the process in fact operates to the benefit of individuals with mental health problems.

Some housing staff in areas where CBL is being implemented certainly thought that those with extra vulnerabilities are struggling to cope with a more demanding process.

> *CBL allows more sensitivity to particular people's needs; but that actually makes it all the more important that they get good help in making choices.*
>
> *Allocations officer, ALMO[19]*

> *For the most vulnerable, the whole process is too stressful, scarey. It really needs a mopping up service, for those who fall through the net.*
>
> *Housing Officer, RSL [125]*

There is also some concern if introduction of CBL coincides with losing what greater priority earlier systems had accorded to mental health vulnerability.

> *I'm not too impressed with the way its worked so far. Having just two bands for priority – that's not sufficiently sensitive to pick out those with real priority needs.*
>
> *Homelessness manager, LA Housing Dept.[5]*

> *It works – there's more choice than before. But we opted out. It doesn't fit with our lettings policy. Except for the very low demand places, we award priority on a points system, based on need, which is more sensitive.*
>
> *Snr Housing Officer, RSL [133]*

> *It needs a quota system, or some other mechanism, to keep back some decent properties, reserved for those who can't manage to bid under the CBL approach.*
>
> *Housing strategy manager, LA Housing Dept [35].*

However, with or without any counter-balancing to retain the priority formerly given to those with particular vulnerabilities, the study also revealed a different aspect of the introduction of CBL, which had not been anticipated. This was a concern expressed by some staff that a CBL approach removed from housing staff their remaining discretion over what is suitable in allocation of properties. This, some feared, ran counter to, and jeopardised, their capacity to manage allocations to build sustainable communities, and the important but often unrecognised sensitivity to individual needs, as discussed earlier.

We must however stress that it was only after the main research outline, and the study's primary outcomes had been agreed, that we were made aware of examples of CBL in the areas of the sample. We have therefore paid attention to this issue, but the study was not set up specifically to look into these issues, and does so only incidentally and in passing.

There is also considerable variation in the way neighbouring authorities have approached the introduction of CBL. This gives reason for even greater caution about drawing any conclusions from such a limited sample frame

That said, the underlying problem may be that CBL has been treated hitherto as essentially a housing issue, and a matter of the best use of housing stock. Those with other perspectives have not always been consulted or involved to judge the overall success from the point of view of the more vulnerable.

This would suggest that when the operation of particular local variants on CBL is reviewed, it is important to involve a wide range of "stakeholders", reflecting the wider role of housing in social care policy.

2.3.4: THE DRIFT TO THE INNER CITY

Many housing practitioners had clear views on the tendency for those with mental health problems to drift towards the cities, and find themselves congregated in the more run down housing in the inner city areas – an aspect of the phenomenon sometimes known as "residential sorting".

For some, the problem was with the housing stock that is available.

> *It's partly the way LA housing stock has become residualised – it's now really the housing of last resort.*
> *Asst Housing manager, LA Housing Dept.[33]*

> *It's because all our stock is so run down. We need to raise the quality of all our stock*
> *Homelessness Officer, LA Housing Dept [66]*

> *They do tend to be single, and single person accommodation tends to be in the more high stress areas, because of the lifestyle so many others lead.*
> *Homelessness Manager, LA Housing Dept [34]*

> *RSL properties tend to be in better condition than LAs'. But we still do have some hard-to-lets. We get " rehabs" – individual*

properties that we do up, and they do tend to be in low demand areas; if we don't know someone has a mental health problem and we place them there, they will have a rougher time. Then there is no local scheme staff to help. They are more isolated, the Housing Officers visit less often, and so problems can build up.

Area Housing Manager, RSL [75]

Others suggested that the problem may be that those with mental health problems may have lower expectations – or no-one to advocate for them.

There's some evidence for that. They aren't pushed into it; perhaps they won't speak up; perhaps they have lowered expectations, lower self image, less assertive. If you're homeless and desperate, you've just got to take whatever comes.

Housing Officer, ALMO [28]

I would guess, if people aren't aware of the benefits they're entitled to, or can't cope with the forms, they'll go to cheaper housing.

Community Assistant, RSL [138]

These can be chaotic people – they don't tend to re-negotiate for re-housing after they have been placed somewhere.

Housing Services Manager, LA Housing Dept [65]

Some however acknowledged that an element of discretion in lettings, together with a concern for the stability of existing or new communities, may contribute to the issue.

It's certainly true of other places; it's a question of filling void properties. In ……., it's more a question of what's right for the neighbourhood. Because if you get it wrong, no-one lets you forget it.

Housing Officer, RSL [112]

It could be true; we try for that not to happen, but it does influence where you put someone, for human reasons and also for the person's own benefit.

Housing Officer, RSL [81]

For others, however, the reverse was true.

No – it's the opposite. It's the voids filling that drives it, but I won't do that, because then the tenancy will just fail. There's no point in doing it, it would waste my time and theirs.

Supported lettings manager, RSL [125]

Generally, the view was that placing vulnerable people with mental health problems in unwelcoming and hostile communities simply serves to worsen

both tenants' own mental health problems, and the housing management problems of high turnover, abandonment, arrears, bad debts, and anti-social behaviour.

Some, however, thought that there could actually be something positive, even protective, in the inner city environment. For some, it may be a more accepting community; for others, it is simply that this is where all the support services tend to be located.

> *Yes; perhaps there's a greater tolerance in the inner city – there's less sense of community pressure if someone has problems. You don't get the NIMBY-ism that you get in more affluent areas.*
>
> *Housing Officer, RSL [103]*

> *But also, the services are in the city; that matters if you have transport issues, can't drive on medication, or can't afford a car.*
>
> *Snr Housing Officer, RSL [133]*

> *It's less so here. People are more parochial, and they want to stay where they know. Some want to be where the support is. If they have family support, they want to stay around there; but if it's professional support they depend on, that tends to be in town.*
>
> *Housing Officer, LA Housing Dept [150]*

> *Unpopular areas? Unpopular with **whom**?!?We operate in areas where other RSLs won't go. But if we provided single person, specialist BME accommodation in run-down areas, it's fine – it's where our community lives, it's where they would want to be*
>
> *Development manager, BME RSL [129]*

Is there sometimes a positive case for constructive congregation? Some recent research[ix] does seem to suggest this, but it needs further corroboration. This is a discussion that has barely begun, and it perhaps may need a different answer in each local circumstance. The key point here is that, via the consultation mechanisms developed by mental health services, mental health service users, and carers, could be asked their views of what is most suitable, in their local circumstances.

2.3.5: THE IMPACT OF HOMELESSNESS

But, whilst other contributing factors are also mentioned, staff consistently suggested that it is homelessness, and the consequent element of urgency in re-housing, that is the crucial stage or trigger in the spiral of decline that leads to congregation in inner city and low-demand housing.

Those who are homeless, it is argued, are under the greatest pressure to take any property that is available. But the properties that most come available in a hurry are those that others have left, and/or did not want – and they are therefore more likely to be the "low demand" or "hard to let" properties.

> *Yes, it's fairly correct that there are more (mentally ill) in the inner city… Often people will have been evicted or otherwise they have had to move, and they are homeless. It's easier to get housed there, and there are all the "hard to lets there".*
>
> *Snr Housing Officer, RSL [133]*

> *Mental health users are no different from any others who need crisis accommodation; it's just that what's available immediately is bound to be the hard to let properties.*
>
> *Area Housing Manager, LA Housing dept.[42]*

> *No, it (ie: inner city drift) doesn't have to happen. If they have the support they need, it doesn't need to happen; but if they don't, and the tenancy fails, then they are homeless, and then they are likely to get a low demand place.*
>
> *Area Housing Manager, RSL [117]*

There was however considerable optimism from some that this tendency can be reversed. Support services aimed at preventing tenancy failure can reduce homelessness. For others, CBL marked a major change, offering choices in the future.

> *We need to put the support in, to prevent the tenancy failing in the first place.*
>
> *Housing, Officer, Homelessness Dept, LA Housing Dept [67]*

> *How to turn it around? Knowing in advance what you're dealing with, and getting in the support, so the tenancy doesn't break down.*
>
> *Housing Officer, RSL [103]*

> *We have choices now; we could perhaps re-house vulnerable people on a temporary basis, and then look again at their needs.*
>
> *Housing manager ALMO [15]*

> *The process (of allocations) needs to become more transparent and accountable, so that you can build in counter-balances.*

Housing manager, LA Housing Dept [11]

It WAS true in the past, but with CBL now, anyone can bid for any property that comes up.
Lettings Officer, ALMO [18]

To summarise:

This (ie: drift) is a generic problem faced by all vulnerable groups – it's not just mental health.
Housing Services Manager, RSL [140]

There's a mix of reasons :- re-housing of people with mental health problems frequently comes from a crisis – then they have less ability to wait for a good offer; they may be less able to make an informed choice, or less able to think through the options; they may be less assertive, less challenging of the condition of the property.
Housing Services Officer, RSL [139]

If it is true that homelessness, and the disempowerment that comes with having to take the first available place, is the key to the drift of vulnerable people into low demand housing, then we may speculate that it is likely to impact most on those already most disempowered. In-patient bed pressures mean that those who are homeless on a hospital ward may have least choice of all, including over when they will be required to leave.

The need for closer and more pro-active co-operation between mental health and housing services is critical. Hospital discharge planning procedures need to be aware of the importance of early contacts with housing services, and of establishing consent from the patient to liase, in order to find the best solution available.

Community team and in-patient ward staff alike need to establish communication channels and early referral procedures with local homelessness services. This will ensure that at the very least, all necessary information can be shared between agencies, in the interests of the individual, to assist with priority assessment, and in advice on suitable temporary accommodation.

The suggestion - from two housing managers - that vulnerable homeless individuals could perhaps be housed, and in secure accommodation, but then offered a further move to a property which may be better suited to their needs, may be helpful. It would need careful evaluation as a practice, as in past years much effort has gone into trying to ensure that homeless people are given an early offer of a settled home.

HJONES 12/12/05 09:48
Deleted: permanent

Nevertheless, attempts at preventing post-admission homelessness via early discharge co-ordination, and/or via floating support, will ease, but will not resolve the tendency towards "drift", if the available housing stock is indeed all "hard to lets". To resolve that aspect of the issue, a deeper, strategic co-ordination is needed.

However, it is noticeable that there was more consistency over the question of drift, or "residential sorting" in the Local Authority staff's responses. RSL staff more often disputed that such a tendency applied in their area or service.

Our interpretation of the variation between local authority and housing association responses rests on the fact that Local Authority housing stock has shrunk considerably over the past 20 years, whereas RSLs' housing stock has been expanding over this period.

The impact of the Right to Buy has meant the loss of the best of the Local Authority housing stock during a period in which their statutory obligations in relation to homelessness and community care have increased. The "residualisation" of Local Authority housing stock appears to be the key feature here[xxii]. RSL stock is generally newer, and less characterised by the development of estates and flats.

Recent studies of disadvantaged people housed by RSLs refute the occurrence of residential sorting[xxiii], at least for the populations studied – single parent families and BME households. But family size and ethnicity are relatively factual, measurable characteristics. In the absence of similarly reliable information on the mental health needs of tenants, we may nevertheless be inclined to infer that it is the condition and location of RSL stock that may account for the generally more "up-beat" response of RSL staff to this concern.

2.4 STRATEGIC CO-ORDINATION

2.4.1: MANAGEMENT INFORMATION SYSTEMS

We have seen earlier that frontline staff have called for better information-sharing over the needs of individuals. Several staff – particularly senior staff – have also suggested the need to collect better information, for management and planning purposes. This is sought, both to make the case for more support services, including more supported accommodation, and in the name of developing a more sensitive lettings policy, and more sensitive response to problems that may arise.

> *There needs to be more research and thought in terms of where people are placed*
>
> *HO, LA Housing Dept [.52]*

> *We need more awareness of who needs support, and then more targeted visits.*
>
> *Housing Officer, LA Housing Dept. [49]*

> *We have choices now. But we need the information to make those choices at a more strategic level.*
>
> *Homelessness Team Manager, LA Housing Section [15]*

> *We are very short of proper supported housing, and we need to be collecting good quality management data, and making a case for developing more.*
>
> *Team manager, ALMO [15]*

Collecting better information on mental health housing needs clearly cannot the responsibility of one agency alone. Both RSL and local authority housing staff saw the local authority, with its existing strategic links with the health service, as the natural agency to take a lead.

> *I would like to see the local authority act to promote more supported housing – like the (agency named) scheme (a purpose-built unit with one-bedroom flats). And I would like to see the local authority taking more of a lead role in seeking greater co-ordination with support services.*
>
> *Waiting lists manager, LA Housing Dept. [46]*

> *If the mental health team came to us and said, "This is our research; there is a need; can you meet it?", then we could. I can see the RSL changing our policy. But it has to be lead by the mental health teams – it would have to be a strategic decision of the Local Authority, to ask the RSLs to co-operate and comply. .*

Development Manager, specialist RSL [129]

> *Where there's a high concentration of people with mental health problems, and not much in support packages, the housing department needs to take a lead in addressing the issue.*
>
> *SHO, LA Housing Dept. [51]*

There are also some imaginative new applications of information systems. One planning manager suggested using computerised mapping (a GIS or "Geographical Information System") to identify both local demand and shortfalls, and suitable properties to earmark for more vulnerable individuals.

2.4.2: "NETWORKED ACCOMMODATION"

The fact that much of social housing is concentrated in certain areas – particularly in the case of local authority housing stock – has been thought of primarily as a problem, in its contribution to the clustering of tenants with support needs in areas with many other social problems. But some have also suggested that this loose clustering may also create an opportunity, in better inter-agency focussing of support services.

> *Support is definitely a success, but without the right housing stock, it doesn't solve all the problems. If we could disperse people around an estate, but keep the support together, that would be best.*
>
> *Homelessness Service Manager, LA Housing Dept [5]*

> *The biggest problem is the lack of medium-supported accommodation; and we need to create more, via the lettings policy. After all, supported accommodation isn't, essentially, a special kind of building – it's really a central point, the support worker, who makes sure all the other agencies are doing bit and working together.*
>
> *Snr Housing Manager, LA Housing Dept [39]*

It was the funding for the support worker/warden/community assistant that distinguished warden-aided or sheltered accommodation from general needs housing properties, plus the fact that the warden was often resident. But, with the growth of floating support, and the option of 24 hr call out for support services, the distinction between the two is no longer so clear-cut in practice.

In some instances, wardens also manage general needs housing in the vicinity, in the same complex, or on the same estate. If they do so, as the people 'on the ground' they are often called upon to deal with the wider problems of mainstream tenants, with or without additional support cost funding. Wardens on site and/or accessible outside 9-5 working hours provide security and peace of mind, as much as they do "hands on" support, to vulnerable individuals.

We found examples of ordinary housing/estate management staff who have taken pride – and evident pleasure – in their ability to absorb disabled or otherwise disadvantaged individuals into mainstream housing, and to develop a balanced and self-sustaining community 'feel'. These staff were in effect recognising the importance of social capital in people's lives, and in developing an estate.

These particular staff seemed to be quite willing to cross the boundary between housing management and housing support tasks. They were, in many instances, RSL staff, in areas with greater delegated local discretion to allocate properties to tenants according to their sense of who will be able to manage. Some suggested that, if the funds were there to allow the time, they might readily take on a wider support role with vulnerable people in the locality.

It is not just housing support work, but also other services, which may benefit from having a local housing base. One RSL, which manages a large block of flats, was planning to release one of the flats, and offer it instead as a local resource centre for local healthcare and welfare rights agencies and community groups to use.

The development of Tenant Compacts was suggested by some respondents as a means of encouraging a more caring attitude between neighbours, alongside other tenant participation initiatives. Most authorities are also now employing neighbourhood wardens, who may have a useful role in providing low-key support and offering safety, and a contact point out of hours to the more vulnerable in their area.

The capacity to use lettings and allocations positively in the building or re-building of sustainable communities, with discretion and sensitivity (but balanced perhaps with greater transparency and accountability) is at the heart of the key role of housing in community building, and in social inclusion: to which we turn, therefore, in the next section.

2.4.3: A MORE HOLISTIC/CORPORATE APPROACH

In relation to individuals, it has been argued that both housing and mental health services need to become more holistic, considering all the needs of an individual, with the significance of housing – not just supported housing - better recognised. But at the strategic level, too, some have suggested a more corporate approach to the analysis of housing needs, and to the development of new schemes, is equally needed.

Overall, staff commented that their available housing stock was not utilised in any planned and cohesive strategy suitable to fulfil the community care needs and obligations that they have to meet. More considered use of existing stock, and development of new housing stock to cater better for mental health needs was rated the third commonest wish expressed by all staff, and the foremost of their top priority wishes.

We need more inter-agency "mapping and gapping".
Area Housing Manager, LA Housing Dept [42]

There is scope for better use of warden-aided accommodation.
Group Principal Manager, ALMO [11]

(Mental health) services are not geared up to engage with the BME community. A more holistic approach would be more acceptable here; and we could actually be part of that.
Housing officer, BME specialist RSL [131]

If the only accommodation available for single persons is in blocks of flats, this may not be most conducive to mental well-being. But, beyond noting that most people would like " a place of their own", there has so far been little research to see what housing is most helpful for people more vulnerable through mental health problems.

Recent consultations[xxiv] however indicate that, for some at least of those least able to live fully independently, warden-aided accommodation may still be more attractive than residential care or complete isolation. For others, "core and cluster" networks may also offer a balance of independence with locally accessible support.

Via Local Implementation Teams and Local Strategic Partnerships, mental health service users and carers could have a say in future on issues of shortfalls in suitable accommodation, housing strategy and stock development, and on allocations policies focussed on social inclusion and social capital.

Nevertheless, we found a number of examples of the imaginative use of existing general needs housing stock to support individuals who might not otherwise have been able to sustain a tenancy, including re-modelling of sheltered housing.

There is the (agency named) model – they have been very successful. They take on the tenancy, and sub-let to individuals coming out of hospital or prison; so they can help apply for grants and benefits and get the place furnished, even before the tenant moves in. They can take on people we wouldn't be willing to try. But then, if it all works, the tenancy is handed back to us, and they become an ordinary tenant.
Housing Officer, RSL [127]

We provided the property, they (RSL) provided the (supported accommodation) project

Asst Area Manager, ALMO [25]

The following examples of a more strategic co-operation between housing and mental health support services were suggested:-

- The re-modelling of surplus or low demand sheltered accommodation for other community care client groups
- Development of Key Ring-type schemes
- Release of some properties to provide a base for community support agencies
- Use of ordinary housing stock in the vicinity of hostels to create move-on accommodation with close support
- Housing on licence to individuals who need support integral with housing management, rather than the "by agreement" model of conventional floating support services. (The 3rd case example earlier illustrates such a situation.)

Such housing-based initiatives need to arise from local opportunities, and to reflect the configuration and relative pressures on services in each locality. More innovative schemes may need careful evaluation, with all stakeholders, including referrers, and users. Nevertheless, the view of so many staff that this is an under-developed area must surely be given some weight.

2.4.4: MONITORING AND AUDIT

Several staff suggested that there needs to be some way to hold mental health services to account, when promised support to tenants is not delivered. Without such accountability, it was suggested, housing services may well be reluctant to house those with a history of difficulties that impinge on the lives of neighbours. Some have suggested a Service Level Agreement, when mental health services want to place an individual with high support needs in mainstream housing.

> *Support plans need to be kept to. We need a way to hold them to account.*
>
> *Lettings Officer, LA Housing Dept [146]*

> *In relation to communication and service delivery issues, there should be performance indicators that question whether mental*

health teams have regular contacts with social housing providers.

Regional Manager, RSL [140]

If people in mental health services want social housing to provide, then there needs to be the knowledge that there will be the back-up.

Snr Area Manager, RSL [123]

I would like to see a contractual agreement to deliver, like there is with SP.

Development manager, RSL [129]

It is perhaps salutary at this point to recall that in the one area where support is now contractual – in relation to Supporting People – there was frequently the complaint that services have often become more inflexible and less accessible since clearer contracted support agreements were introduced.

But it may be that there is a wider underlying principle here – that community mental health, if it is to succeed, needs to recognise a wider community accountability, and not simply the responsibility of medicine to its own internal reporting structures.

Others have argued that there is a problem equally with the way that housing services are monitored – that the performance of housing services is measured primarily quantitatively, and by rent arrears, void periods and so on - which does not recognise the true complexity of social housing's real role.

*We can hit all our targets for allocations and voids, but what's the **quality** behind it?*

Area Housing manager, LA Housing Dept [147]

As an authority, we have corporate objectives for building sustainable communities; but I only have specific targets just for housing, that don't join up with the others

Area Housing Manager, ALMO [24]

Earmarking and holding a suitable vacant property for a patient coming up for discharge, for example, may have a short-term financial cost to the housing agency, in rental foregone. But to see this as *in*efficiency, is to misconstrue the vital role of housing in the community care network, and add disapproval to financial cost.

In exceptional cases - ie: cases of protracted delay before discharge and very high sensitivity - Health or SSD budgets may need to offset some of the cost. An alternative approach would be to devise

an amendment to HB regulations; but this would take longer, and would remove the incentive for H&SSD to prioritise such cases.

We're constantly monitored over things like equalities, with allocations for the BME community. But no-body monitors how we handle community care issues.

Allocations Officer, LA Housing Dept [146]

What I would like to see is more joined-up targets! It needs more time, to resolve mental health issues properly. There ought to be a discretion factor, that allows us to miss some KPIs in order to give us time, to take a more multi-agency approach. It could be monitored, accountable – and it could be valued.

Allocations and Homelessness manager, LA Housing Dept [34]

The clearest example to date of a holistic/corporate cross-agency vision of the role of housing in community care and community safety issues has been the development of the Supporting People programme. Audit Commission reviews of SP services now comment on the extent to which inter-agency vision and strategy have been achieved, in the use of SP grant funds at local level.

Audit Commission inspections of local authority housing strategies also have a role in assessing the authority's efforts in the management and prevention of homelessness[xxv]. It is therefore arguable that assessments of a more "joined up" use of housing stock should consider more closely inter-agency efforts to address the issue of those who are "vulnerably", or "unhelpfully" housed.

It is equally clear that housing services cannot make inter-agency efforts on their own. Yet the "scorecard" system for star rating for mental health services made little reference to inter-agency work, and none at all to work with, or recognition of, patients' housing needs. At this point in time, it remains to be seen whether the new "annual health checks" will redress this apparent oversight[xxvi].

Yet the vision of social inclusion outlined in the SEU report seems clearly to imply that "action across government" will mean action to encourage all agencies in society to co-operate to meet the mental health needs of our citizens.

If combined with a greater recognition of the need and the scope for greater inter-agency co-operation and co-ordination between health and housing services over individual need, the concerns expressed here could therefore be developed into a new quality measure in the inspection of both local housing **and** mental health strategies.

Others have suggested[xxvii] that there needs to be a principle established, to the effect that social landlords have a duty of care towards tenants with mental

health problems. This, it is argued, would help to ensure that tenancy enforcement action could not take place without the housing provider making all reasonable attempts to ascertain if an individual has mental health issues underlying their rent arrears or anti-social behaviour.

2.5 INTER-AGENCY PRACTICE AND LOCAL CONTEXT

2.5.1: "BEST FIT PRACTICE"

The study had originally set out to identify what housing staff themselves saw as good practice, in housing those with mental health problems; and what are the impediments to good practice. With its open-ended interview questions, and with the "3 wishes" question to focus interviewees' priorities for change, the study has certainly outlined a wide ranging agenda for improvement in communications and co-working between services. But good practice is not a simple concept. Before we can state what is good practice, we must still identify what the practical problem is, what the issues are, that must be handled well – what it is that "good" practice is actually "good at".

Firstly, good practice is not identified or defined as "good" simply by contrast with other, "less good" practice. It is defined as good primarily in relation to a set of values, and then in relation to a perceived problem with current practice. Practice will then be "good" if it resolves, or simply tackles, the identified problems successfully, within the values of the service. The values that have driven this study are those of social inclusion for individuals with mental health problems. As researchers, we have found those values apparently shared by the great majority of staff we have interviewed. Lack of commitment to those values does not appear to be the primary problem to be addressed.

Secondly, good practice in a multi-agency service environment is inevitably more complex. In a multi-agency environment, other key stakeholders – mental health services, and arguably, also tenants' associations – must also contribute their own views. But in a service sector, what is identified as good must be corroborated by feedback from service users – tenants and patients. Any identification of good practice must be done "in the round", to see what is good from all angles. Experience[xxviii] here suggests that gathering a broader perspective is not something that can be rushed, particularly where it must involve consultation with service users.

It seems most likely that evaluation of actual services and practices in this area will need to be on-going, and to involve a wide range of stakeholders. Through the discussions that NIMHE is now establishing at national and regional level with housing agencies, we shall be better able to assess to what extent there is a real appetite locally for more in-depth and on-going work on benchmarking of "joined up" practice.

Nevertheless, we can at least already infer and suggest that what is good, will be good in its particular locality context. Some practice improvements are likely to be beneficial in all areas. But others may be appropriate or not, according to the nature of the area, and in the case of RSLs, the extent to which any one housing agency has stock, and staff, in each area.

What is needed, what is viable, for example, in an inner city environment, where we may expect a greater concentration both of mental health problems and of services, may not be needed or not viable in a more dispersed environment such as a rural area. What works for a large organisation, a major social housing provider in one locality, may not be appropriate for another, with smaller clusters of stock dispersed in many different areas (as RSL stock often will be). The suggestions below represent therefore only our first, and somewhat tentative attempt to locate some of the practices that staff had raised within a locality context, taking into account the range of need, the logistics of delivery, and the cost-benefit of attending meetings. Such essentially pragmatic concerns must always underlie any attempt to identify best fit practice.

2.5.1: WHAT WORKS IN CONTEXT

All areas and services should perhaps now consider developing:

- Mental health training for housing staff
- Support needs information gathering with tenants
- CMHT referral mechanisms for housing staff
- Information-sharing protocols addressing housing issues
- A directory of local mental health services
- A policy commitment to joint work and needs analysis

In addition, services could consider adopting, as inter-agency initiatives, one or more of the following structures, according to the population density of the area, and the extent to which each housing agency has a significant presence as a provider in the locality.

- A Local Social Housing Forum for Vulnerable Adults
- A Wider-area Mental Health Housing Forum
- A Local Mental Health Housing Forum
- A One-Stop Shop (for all vulnerable client groups)
- A One-Stop Shop (specific to mental health)
- Mental Health Liaison Linkworkers in housing
- Housing/Homelessness Liaison Linkworkers in CMHTs

- Information systems to identify mental health needs of tenants and housing needs of patients/service users.

We would suggest, for example, that in areas of low density, a generic social housing forum would be sufficient in each actual locality. An RSL with little local stock could arrange for a member of staff to attend this local forum, simply to keep track of policy and service developments in their locality. Some senior staff however, or specialist staff, might attend a wider area specialist mental health forum, and cascade information to local staff. In an inner-city area, however, a generally greater concentration of individuals with poor mental health might suggest both the need for a mental health forum at local level, and for greater participation from frontline staff.

A major local housing provider (such as the local authority or ALMO) might well develop a linkworker arrangement, and that worker might then attend any mental health housing forum. Similar considerations may drive the development of One-Stop Shops for advice and referral, and the value in collecting better management information on needs, for planning and service development purposes.

2.5.2: GOOD PRACTICE "ON THE GROUND"

Finally, it needs to be said that good practice does not have to be innovative, or a big idea. It may be a simple thing, like empathy, or persistence. In the course of these interviews, we saw much that we ourselves thought was good, committed practice, just as we found what we can only describe as a thirst for improved practice.

We found that many staff were noticeably reluctant to identify what they themselves did as good practice - even where others in the same office suggested that it was. It seems that, when committed staff are doing their best, they tend to see most clearly what stops them doing more. Modesty and stoicism therefore vied with concern and frustration, in their accounts of what more needs to be done.

There may be other inhibitions to identifying practice as "good". At least one service that we were told about – highly commended by all we spoke to in that area – was reluctant to be identified as an example of good practice as part of a related government report. They feared that if they were identified so, they would become a goldfish bowl, and swamped with requests for advice and visits.

At a time when much of the good work done by housing staff is often un-recognised, when there seems to be a gulf between the concept of housing as a simple consumer good, and the reality of social housing as a key resource for community care policy, it may be that for many, good practice has consisted in filling the gap, in "going the extra mile".

This is perhaps precisely what the Social Exclusion Unit's report had in mind, when it argued that mental health is not the concern of mental health services alone, but is a concern for us all. The findings of this study suggest that, for that ambition to become a reality, there will need to be greater appreciation of the contribution that other services, notably housing, can and do make.

3: Conclusion

3.1 SUMMARY AND IMPLICATIONS

In this study we have looked both at the issues raised by housing staff, and at the kind of structures or approaches that they have identified as helpful. Some of the changes or developments that they would wish to see can be implemented by a single agency, but the majority require a quite new degree of inter-agency co-operation. Without doubt the most consistent and striking finding of this study is that there is a very strong desire for closer co-working between housing and mental health staff, at all levels, across the social housing sector as a whole.

Social housing emerges as an untapped reservoir of resources of real significance in community mental health. Recognising the importance of housing, and the involvement of housing staff, and finding ways to work more closely with housing, both at individual tenant/casework levels, and at strategic/service development levels, would be a major step forward for the social inclusion agenda in mental health.

Housing services, meanwhile, have been grappling with their role as providers for some of the most vulnerable and disadvantaged of our citizens, all too often, it would appear, with little advice, assistance, or appreciation from mental health services. Social housing services operate in a world buffeted by constant change, constant demand, and constant new directions.

Housing services nevertheless have much to gain, and surely little to lose,

- in better recognition of social housing's wider potential and the complexity of its task
- in better understanding and closer co-working to resolve the problems of some of its more challenging tenants
- in better strategic partnership that would guide deployment of resources to manage the role that housing must play more successfully.

3.1.1: Recognition and awareness

The single issue that was most commonly identified across all the interviews was the need for recognition, better understanding, and appreciation of the role that housing, and housing management, actually plays in maintaining vulnerable individuals in the community.

Community care policies since the 1960s, combined with changes in the housing market (including the Right to Buy, which has severely reduced Local Authority housing stock, and the growing responsibilities of local authorities to house vulnerable individuals despite their shrinking stock) have changed the character and role of social housing, to the point where ordinary, mainstream social housing now supports the bulk of individuals with community care needs.

Meanwhile, despite a growing recognition within mental health circles of, for example, the negative symptoms of schizophrenia in general activities of daily living, such problems are perhaps inevitably given a lower priority by hard-pressed mental health services. It is frequently housing management staff that find themselves called in to deal with the resultant difficulties. There are also, meanwhile, some severe mental health problems which are perhaps primarily seen in a housing management context, and dealt with by housing staff:- paraphrenia; obsessive compulsive hoarding; personality disorder; low self care and neglect through depression, and extreme isolation through depression or agoraphobia. Often such conditions only come to light when housing staff visit over repairs or building maintenance issues.

Housing staff have accumulated considerable experience, professionalism and expertise over these years in dealing with the day-to-day problems of the most vulnerable and troubled. They tend to feel that this expertise is not recognised by mental health staff. Housing staff in this survey have felt generally that the majority of mental health workers – with usually a few honourable exceptions in each locality – had little grasp of housing and re-housing processes, of homelessness services, or of the day-to-day involvement of housing management staff in managing complex situations including relations with neighbours.

The statutory requirement for local housing authorities to secure accommodation for people who are homeless through no fault of their own and who have priority need because they are "vulnerable" in some way can lead to a situation in which " a less desirable stock housed the least desired tenants[xxix]", to the detriment of both the area and the vulnerable individuals "placed" there. It is very easy to activate a spiral that sends "low demand" into free fall[xxx]. This in turn has lead to an increased reliance on housing management to combat anti-social behaviour through tenancy enforcement procedures and Anti Social Behaviour Orders, which may sit uneasily at times with community care values and services. Housing management often seems to be left not only to manage tenancies and estates, but also society's more contradictory attitudes to community care.

Given their role in dealing with anti-social behaviour, and given their powers of tenancy enforcement, housing staff are often keenly aware that underneath neighbour complaints there may be un-met community care needs, and a punitive/confrontational approach on its own is insufficient. Nevertheless they often struggle to get mental health team staff involved early enough to identify the right course of action, or to jointly work to resolve issues (see next section) in the best interests of the individual and the wider community.

But the key to understanding the unique place of social housing in community care is to realise that housing management may be responsible for the entire block, estate or even neighbourhood, and that it must balance responsibilities towards individual tenants with the rights of, and its responsibilities to, the broader community. All too often this is seen as compromising, or as incompatible with, a legitimate role in community mental health.

In recent years, mental health services have focussed increasingly on individual casework. Housing management on the other hand has had a major and growing role in neighbourhood management, neighbourhood renewal, community safety and the maintenance of sustainable communities. In some respects housing now deals with many of the community work and social inclusion issues that mental health services do not.

Mixed feelings have been expressed by housing management staff – and particularly by their managers – on the growing need for intensive housing management and community based initiatives. Many housing staff see this aspect as one of the more challenging and rewarding parts of their work. Others see themselves as simply dumped upon with problems that they are not equipped to deal with, but wishing even so to co-work with those they see as more skilled, more knowledgeable, and certainly more responsible.

Some of the varied responses may reflect the underlying culture of the organisation – and in particular the varied character of housing associations, which have more freedom to chose their preferred market "niche". But over all, the second most commonly expressed wish from housing management staff everywhere was for mental health awareness training – often in combination with information and training on how to access services, when concerned about a tenant. But it was also quite commonly said that mental health team staff lack understanding of housing processes, and that perhaps one or two mental health staff in each CMHT likewise could have "housing awareness training".

There is a range of views as to who would need and benefit from what level of training, but broadly speaking all workers interviewed felt the need to have someone – and preferably someone within their own organisation or service – to whom they could turn for informal advice on management and referral – a linkworker. A number of housing staff do have experiences of shadowing mental health staff, and vice versa (this happens most often with homeless persons services, where there are sometimes designated mental health and homelessness staff).

Many other staff felt that, as part of general induction for housing management and mental health staff, shadowing would help in developing both understanding, and local co-working relationships. But for this to be extended, some fundamental issues around communications must first be addressed.

3.1.2: Communications and joint working

Communication and joint working is in part a matter of attitude and of priorities. But in this study we have looked more closely at the structures and processes that assist and obstruct communication and joint working. The third most consistently raised concern that arose in this study was the need for communication channels to underpin closer co-operation between housing and mental health services. Housing staff repeatedly expressed the desire and the need for clear agreed channels of communication, for advice and, where need be, for referrals to mental health services, and for protocols over information sharing.

Throughout there were calls for mental health staff to be more pro-active about contacting housing staff, and about obtaining service users' consent to discuss issues of concern. This was particularly so for homeless persons services, which need information on an individual's eligibility for re-housing where the individual seeking to be re-housed can be presumed to have a real interest in having such information passed to the housing staff.

But for on-going work with housing management staff, most felt that some inter-agency confidentiality policy and procedure is clearly needed, and many expressed frustration that some services have no procedure to allow housing staff to make formal referrals directly, or to get informal advice, even on a "need to know" basis, on management of complex and often fraught situations. In some areas such policies exist, but are sometimes ambiguous as to whether they include housing staff. In others, it is not clear that they have been communicated to frontline housing staff.

There seems to be no general consistency in the responses of mental health teams to requests for information, or for involvement, from housing staff, and responses are based on relationships of trust developing between individual workers from each agency over a period of time. Informal links do work; but they should not be relied upon.

Many housing services have actually identified – usually informally – a particular individual who acts as a "linkworker" within that team – someone who is more knowledgeable on mental health issues and maintained contacts with mental health staff. Those that had not already done so repeatedly suggested that it was what they needed to do. Some looked to the expertise of managing agents, or of housing support providers, with whom they have contractual or other regular links.

Many likewise hoped for - and some had actually found – an equivalent person or opposite number within the local mental health teams whom they could turn to, either formally or informally. Still others expressed a preference for a more formal and organised local contact point ("like NHS Direct") to which they could reliably turn for advice and possible referral where appropriate. Several services suggested a local forum where those with an interest in mental health services could meet periodically to talk over issues arising and raise individual cases. There were several examples of this happening, and where it does happen, it is universally welcomed.

With better understanding of each other's respective roles and powers – and limitations – housing management services continuously ask for more joint working over tenancy management for people with mental health problems. Many – but not all - housing staff were aware of and sympathetic to the very stretched resources and limited statutory powers of mental health services.

Yet they still wish to see a more pro-active involvement; and this applies in particular to homeless in-patients, with whom the need may be most acute. They are conscious that their own powers of tenancy enforcement need to be informed and balanced by community care responsibilities of the local authority.

"*There is little value in evicting someone who will then be re-housed as homeless and vulnerable. At best you are only moving the problem around and probably making it worse".*

They are aware, however, that such powers as they do have can be used to confront individuals who do not accept that they may need mental health team help, and with sufficient understanding and trust developing between the key staff on each side, would wish to see co-operation (a "tough love" or "good cop/bad cop" routine) developing over anti-social behaviour.

For want of such pro-active engagement from mental health staff, housing management talk of sometimes having to take enforcement action, simply to "flush out" the care staff and to them get involved. They do not see this as good inter-agency practice, but on occasion appear to have no alternative.

There is a broad welcome for floating "housing-related support" services provided now primarily under the Supporting People programme. However, concerns were often expressed that SP terms and contracts may mean that these services are not always as flexible as they once were, and need to be. There is a particularly broad welcome for generic services; i.e. those that individuals can access without need to define themselves as having a mental health problem, before they can obtain help.

In many instances, this kind of support work is still being undertaken by housing staff, either with other funding sources contributing, or simply because the floating support services are stretched and sometimes unavailable for particular client groups. Some managers view with a mixture of pride and anxiety the extent to which their staff will "go the extra mile" in trying to assist or resolve disputes. They feel that they may be doing necessary work but also may be taking on responsibility for which they are not trained and not responsible.

Overall, however, there is a general perception that there is simply not enough support, either by mental health care staff, through floating support, or in supported accommodation, so that many individuals are left alone to cope with a full tenancy. Some have referred to the potential contribution of maximising what support there is by using general needs housing in more imaginative ways. To this we therefore turn for the final section.

3.1.3: Strategic co-ordination

As suggested earlier, in the absence of better strategic understanding, vision, and co-ordination, individuals with community care needs will often tend to be congregated in the more unsatisfactory housing stock. This is not good for the individuals or for the area, or for the neighbourhood renewal task in which housing is frequently engaged.

A number of examples were quoted of low demand sheltered accommodation and/or other suitable housing stock being given over to mental health or community care services for specialist use. Suggestions have been made of such approaches as KeyRing (which provides low level community based and peer support for people with learning disabilities); leasing of cluster flats in the vicinity of supported accommodation schemes for move-on and for on-going after-care support, as appropriate, could be encouraged.

There is an evident need for more such fresh thinking about the optimum usage of existing housing stock. A vision is needed which is both more holistic – meeting the overall needs of the whole individual – and more corporate – bringing together all agencies with responsibility for some part of the picture; and more imaginative and ground-breaking.

Several staff suggested that mental health and housing services need to co-operate, both to share dilemmas and to identify the true housing needs of those with mental health problems. The analogy was used of the way in which the needs of older people were addressed by the growth of sheltered accommodation in the latter half of the 20th Century. The proposal was that areas should develop a mental health and housing strategy, combining resources and knowledge wherever possible, to produce new schemes jointly. This need has also been emphasised by recent Audit Commission inspections of Supporting People services.

Such proposals need to be considered with care, as they could well send policy away from providing accommodation in ordinary homes to providing schemes designed by "experts". But the involvement of users and carers has developed considerably in mental health services in recent years, and the consultation mechanisms now exist for users' views on their housing needs and preferences to be fully heard. All that is needed is for this issue to be taken on board, as one for mental health services to address.

Finally, some housing staff commented that the targets by which their own performance is measured are not "joined up" with other targets. They were not perceived as capturing the whole range of their work, or encouraging efforts for more constructive use of housing. Requirements to re-let voids, or to re-house individuals within fixed periods, are not usually compatible with taking the time and sensitivity needed to find the most suitable accommodation for more vulnerable tenants.

Discretion given to frontline and middle management staff – but through more transparent and accountable procedures – to manage their stock with an eye to community care needs, alongside neighbourhood renewal issues, may need to be "incentivized". It was suggested that audit inspection should assess housing services' performance in terms of corporate responsibilities in community care, as well as housing management efficiency in areas such as arrears recovery and voids management. This has been described as the need for "more joined-up targets".

NB: There would seem to be a similar case for the assessment of mental health services to consider the extent to which inter-agency work is featured and facilitated in efforts aimed towards social inclusion practice.

3.2 FUTURE DIRECTIONS

This study identifies a significant and as yet largely untapped opportunity for partnership in community mental health. It finds a strong case for better recognition of the deeper involvement of housing and housing management services in efforts to support and sustain individuals with mental health problems in their own homes.

The principal conclusion from this study is that the majority of mainstream or "general needs" housing staff interviewed saw themselves as providing a significant and valuable, but often un-sung role in community mental health care. They were very willing to continue in this role, but argued that there needs to be better inter-agency underpinning for this work.

The input of statutory mental health services should therefore work with, and complement, the work of housing, rather than operating in isolation or even presumed opposition. Equally the regulation and monitoring of housing organisations needs to recognise the key role that social housing now plays in accommodating the most vulnerable. Existing approaches to monitoring and regulation do not appear to encourage co-working or imaginative initiatives, and any disincentives to good practice should be removed.

3.2.1 THREE KEY MESSAGES

This study has lead to several very broad-ranging conclusions as to the future linkages between mental health and housing services.

We conclude:-

1: that social housing has become the principal vehicle in practice for successive governments' policy commitments to treat and to house the most vulnerable in the community; that social housing should therefore now be seen as one of the essential resources of community care; that this community care role needs to be better recognised; and that what is seen as good practice in social housing should be seen in that light.

2: that mental health services cannot continue to regard the housing needs of their clientele – and any shortages of suitable housing - as essentially the responsibility of some other agency; but rather, mental health services should be positively engaging in identifying these housing needs, working with local housing agencies on fully comprehensive local needs analysis and strategies, and feeding this information on needs into regional and national housing strategies.

3. that, with the development of floating support and of networked housing, and with a growing awareness of the role of housing in building sustainable, inclusive communities, general needs social housing and supported accommodation cannot any longer be seen as separate worlds. Rather, they must be seen as part of a continuum of housing services, which also includes shared ownership and private sector leasing; floating support, networked housing, and supported accommodation; rehabilitation units, and residential care.

A "whole systems" approach to the meeting housing and support needs of those with mental health problems needs to encompass this whole range; and developing closer relations with housing services must be a priority for any comprehensive local mental health accommodation strategy.

From these three broad positions stem the recommendations below both for immediate practical measures at local level to improve communications and co-operation between these two sectors, and for guidance and direction from national audit and quality assurance bodies, to monitor and incentivise closer co-operation.

From this, we might tentatively suggest the following recommendations, for further discussion.

3.2.2 RECOMMENDATIONS

Based on the issues raised in this study, we suggest

housing services could:

- Incorporate basic mental health awareness training into the training of all frontline staff. (NB: It is seen as good practice for mental health service users to be involved in such training programmes wherever possible.)
- Provide additional training for relevant staff on accessing mental health services.
- Review eligibility criteria and lettings policies to ensure sensitive allocations to those more vulnerable through adverse mental health.
- Review administrative and IT systems to ensure that the organisation can recognise and respond effectively to the needs of those tenants who may be vulnerable because of their mental health problem
- Ensure that existing tenants are aware of available housing support services, and encourage an atmosphere in which no shame or blame is attached to the need for support.
- Consider developing selected staff to be "linkworkers", with a more in-depth knowledge of mental health issues and the ability to develop contacts with local mental health services.

mental health services could:

- Ensure that directories that identify local mental health services, and how to access them, are regularly disseminated to local housing providers.
- Establish clear and workable channels for advice and referral that housing providers can use.
- Encourage a more pro-active inter-agency response from mental health staff to resolve issues that can lead to tenancy breakdown, including a more pro-active approach to obtaining consent to share information with housing staff.
- Establish early referral agreements between in-patient wards and homeless persons' services.
- Through assessment and CPA review processes, gather more systematic information on un-met housing needs, including unsatisfactory or unhelpful housing, so that use can be made of this in joint planning of services with housing providers.

mental health and housing services, working together, could:

- Review information-sharing protocols to ensure that the particular information needs of housing services are appreciated and specifically addressed.
- Ensure that agreed protocols are in place to ascertain whether a tenant may have an underlying mental health problem, and to elicit care and support services' assistance to resolve difficulties before steps are taken that would lead to termination of a tenancy.
- Encourage and facilitate shadowing between staff of different agencies, joint training, inter-agency forums, and other local measures to enhance co-operation and joint working at both casework and strategic levels.
- Consult with mental health service users and carers over best use of available housing stock, and in identifying shortfalls in suitable housing, to assist with future development planning.

How then could Supporting People contribute to the social inclusion agenda in housing?

- SP services and commissioners need to ensure that mainstream ("general needs") housing services are involved in identifying needs, shortfalls, and priorities for support services.

- SP Commissioning Bodies could consider social inclusion in mental health as a key strategic aim, when assessing the value and relevance of generic and/or in-house support services.

- Consulting widely, in the light of the new national strategy and any local mental health accommodation strategy, on the most effective balance of residential care, supported accommodation and floating support services, and the interplay between them, to meet local needs, for maximum flexibility and responsiveness.

- Working with local Mental Health Trusts and healthcare commissioners involved in modernization and re-design of existing services, to identify the budgets and the resources locally in each sector that can be developed towards providing more comprehensive and more robust integrated supports in the community.

How could Central Government and national regulatory bodies contribute to the social inclusion agenda in housing?

- Audit Commission inspections assessing the success of housing services in delivering excellence in housing management could consider the extent to which local authorities reconcile their strategic responsibilities in housing with those in community care.

- Audit Commission inspections of the RSL sector could similarly assess RSLs' contribution to local housing and community care strategies.

- The Dept of Health could consider developing a measure of successful and/or co-operative inter-agency working, as part of the "scorecard" of criteria for star rating of mental health services.

- ODPM and DoH (via NIMHE) could explore ways to strengthen the co-ordination of policy guidance that impacts on inter-agency co-operation, encourage good practice and commissioning of further "bridge-building" services and research.

3.3 THE NEXT STEPS

Any improvements in communications and co-working between housing and mental health services must carry the staff at the frontline with them, building on the improvements that frontline staff themselves would wish to make happen. NIMHE/CSIP wishes to encourage and wherever possible to facilitate local initiatives that bring together housing and mental health services constructively at a local level.

Meanwhile, at national level, there is currently a new focus on inter-agency and inter-departmental "ownership" of the issues of social inclusion in mental health, given further impetus by the SEU report, the new Supporting People national strategy, and the Health and Social Care White paper.

HJONES 12/12/05 09:36
Formatted: Bullets and Numbering

NIMHE/CSIP has a crucial lead role in relation to mental health services, in implementing the SEU report, and in ensuring that the statutory services deliver their part of the new partnerships "on the ground" that need to develop. There is also a constructive growing relationship with ODPM, to bring housing, homelessness, and housing-related support into the frame.

A national steering group – the NIMHE Housing Reference Group[xxxi] - has now been established to oversee this evolving agenda, and the forging of improved links between health and housing services across all regions. A Practice Exchange Network is being created, using NIMHE's Knowledge Community and the National Social Inclusion Programme web communications as platforms for bringing services and initiatives together nationally. These sites will be accessible not just to mental health services, but also to housing services, and to users and carers.

Robin Johnson 11/3/06 16:37
Deleted: using Reference Group?]

We hope therefore that this report and its various findings may be both timely and helpful in the growing integration of health and housing concerns, in local practice, and in overall policy and strategy.

Robin Johnson
RJA consultancy
May 2006

Appendix A

ACKNOWLEDGEMENTS

We would like to thank the following organisations for their participation, without which this study would not have been possible:-

- Arches Housing Association
- Barnsley Housing Department
- Berneslai Homes
- Chevin Housing Association
- Craven Housing Association
- Doncaster Housing Department
- English Churches Housing Association
- Hallam Housing Association
- Havelock Housing Association
- Leeds Federated Housing Association
- Longhurst Housing Association
- Habinteg Housing Association
- Nashayman Housing Association
- North British Housing Association
- Northern Counties Housing Association
- North Lincolnshire Housing Department
- North East Lincolnshire Housing Department
- Rotherham Housing Department
- Sanctuary Housing Association
- Sheffield Homes
- Sheffield Housing Department
- Yorkshire Metropolitan Housing Association

We are particularly grateful in addition to all the members of the NIMHE NEY&H RDC general needs housing steering group, whose support and guidance, often at short notice, has been crucial:-

- Colin Williams (NIMHE) - chair
- Derek Newton (Hull & East Riding Mental Health NHS Trust)
- Dick Ikin (East Riding Housing Department)
- Fiona Cook (SITRA)
- Paul Hayes (Chevin Housing Association)
- Sheila Bamford (Horton Housing Association)

The RJA research team were: Robin Johnson, Chris Griffiths, Tony Nottingham
Report writing was by Robin Johnson & Chris Griffiths
Layout and typography by Chris Treweek

APPENDIX Bi

Question: If you had three wishes, what would you wish for?

		1st wish				2nd wish				3rd wish				3 wishes		
		S	**V**	**T**		**S**	**V**	**T**		**S**	**V**	**T**		**S**	**V**	**T**
Code																
A		0	2	**2**		0	1	**1**		0	3	**3**		0	6	**6**
C		5	11	**16**		4	7	**11**		4	4	**8**		13	22	**35**
F		4	2	**6**		6	3	**9**		3	2	**5**		13	7	**20**
H		5	14	**19**		6	8	**14**		3	9	**12**		14	31	**45**
I		1	9	**10**		4	23	**27**		0	23	**23**		5	55	**60**
L		12	4	**16**		5	5	**10**		6	4	**10**		23	13	**35**
N		0	0	**0**		0	4	**4**		0	1	**1**		0	5	**5**
O		9	5	**14**		3	1	**4**		6	0	**6**		18	6	**24**
P		2	2	**4**		1	2	**3**		0	3	**3**		3	7	**10**
R		6	11	**17**		3	3	**6**		4	7	**11**		13	21	**34**
S		1	6	**7**		0	6	**6**		0	5	**5**		1	17	**18**
U		0	1	**1**		3	1	**4**		1	2	**3**		4	4	**8**
V		1	2	**3**		3	1	**4**		0	0	**0**		4	3	**7**
W		3	8	**11**		9	22	**31**		6	18	**24**		18	48	**66**
X		0	0	**0**		2	1	**3**		6	1	**7**		8	2	**10**
Z		0	0	**0**		0	0	**0**		9	0	**9**		9	0	**9**
WX		0	5	**5**		10	1	**11**		6	2	**8**		16	8	**24**
IU		5	0	**5**		5	3	**8**		5	1	**6**		15	4	**19**
IH		0	0	**0**		5	4	**9**		0	5	**5**		5	9	**14**
RZ		5	0	**5**		**0**	**0**	**0**		0	5	**5**		5	5	**10**

S = Simple V = Variant T = Total

Please note: this is a codified summary of the views expressed at interviews.
For codes, see Appendix Aii.

APPENDIX Bii

Question: If you had three wishes, what would you wish for?

Database codings

A	allocations with mental health sensitivity
C	co-working
D	shadowing of staff
F	local forum for sharing issues
FI	forum for discussion of cases/individuals
FIP	local placements panel
FN	generic neighbourhood forum
H	holistic/corporate approach in service development
HA	positive discrimination practice
HAN	building community networks via sensitive lettings
HN	identifying suitable stock for mh use
HR	targets and KPIs for community care housing policies
HV	mh services to take the lead in gathering info on needs
I	information-sharing on individuals
IA	gathering information at sign-up
IH	needs analysis for management/development purposes
IU	directory on local services
L	linkworkers within housing service
N	neighbourhood renewal approach
O	one-stop shop for advice and referral
OL	linkworkers within mh service (i.e.: for advice and referral)
P	procedures available to housing services (e.g.: referral)
R	recognition of housing's value/role/potential
S	support services issue
SP	Supporting People programme (concerns over)
U	understanding of each agency's processes and procedures
V	pro-active involvement from CMHTs
W	mental health awareness training
WN	public awareness campaign
WX	training on both awareness and accessing service
X	training on accessing mh services

Appendix C: Glossary

Audit Commission
An independent body which is responsible for ensuring that public money is used economically, efficiently and efficaciously. The Audit Commission carries out inspections of local government, housing, including housing associations, health and criminal justice services.

ALMO
Arm's Length Management Organisation: an ALMO is a company, set up by a local authority, to manage, maintain and improve it's local housing stock. An ALMO may raise additional finances in its own right, but does not trade for profit, and the local authority remains the landlord, the ALMO acting as managing agents for the authority.

Chartered Institute of Housing
The Chartered Institute of Housing is the professional organisation for people who work in housing. Its purpose is to maximise the contribution housing professionals make to the well-being of communities.

CMHT
Community Mental Health Team: a grouping of mental health professionals who provide an integrated service in and for any one locality. A CMHT will typically consist of psychiatrists, community psychiatric nurses, and usually one or more social workers, perhaps also occupational therapists and psychologists, sharing office premises, admin and reception facilities.
NB: there may sometimes be more than one CMHT operating in any one area, with specialist roles, or there may be sub-groupings within the CMHT.

CPA (in mental health)
Care Programme Approach: a policy initiative from the 1990s, now the cornerstone of community mental health care for individuals with long-term mental health needs, which is intended to ensure that every such individual has a full assessment, an identified keyworker or care co-ordinator, and a written care plan, which spells out what care services will be provided, and by whom, and is reviewed periodically.
NB: any of the professionals in a CMHT (see above) might in principle be CPA keyworker for any one particular service user.

CPA (in local authority)
Comprehensive Performance Assessment

CPN
Community Psychiatric Nurse: a trained psychiatric nurse, working primarily with patients in their own homes.
NB: Most CPNs will work in CMHTs (see above) alongside other professionals, to provide an integrated service.

Extra care
A combination of healthcare and/or social care and support services, provided in a sheltered housing scheme on an individualised basis (ie: as needed).

HoNOS scales
Health of the Nation Outcome Scales: a widely accepted measure of patient health, involving a numerical scoring on 12 dimensions. The last three concern primarily psycho-social functioning.

Housing Association
A voluntary organisation set up specifically to provide social housing. An association registered with the Housing Corporation is then known as a Registered Social Landlord, or RSL.

Housing Corporation
The Housing Corporation is the government agency which registers, regulates and funds over 2,000 social landlords in England – which between them provide around 1.9 ,million homes. The Corporation has an important role as a promoter of good practice in the social housing sector.

LIT
Local Implementation Team; an inter-agency grouping of representatives of local agencies, service users and carers, responsible for implementation at local level of the National Service Framework for Mental Health.

LSP
Local Strategic Partnership

LSVT
Large Scale Voluntary Transfer; the transfer, after a vote in favour by tenants (hence "voluntary"), of local authority housing stock (hence "large scale") to a new agency, such as an RSL. In some cases, an entirely new RSL is created specifically for the purpose. NB: In the case of an ALMO, the stock is retained by the local authority, but the management is taken over by the new organisation.

NIMHE
National Institute for Mental Health for England. Part of the Care Services Improvement Partnership, NIMHE's role is to encourage new thinking and new practice in mental health service provision. NIMHE is identified as the lead agency for implementation of the recent Social Exclusion Unit Report on social inclusion and mental health, which includes a section on working with housing services and issues.

RSL
Registered Social Landlord; see Housing Association.

Residential sorting
The combination of processes, both formal and informal, that results in spatial separation of the population by socio-demographic characteristics.

References[xxxii]

[i] SEU *Mental Health and Social Exclusion*, ODPM, (June 2004): also ODPM, *Action on mental health; a guide to promoting social inclusion*, (esp. Factsheet 6 – Mental Health and Housing. ODPM, (Oct 2004)

[ii]The key reports from this study will be available on the NIMHE website in the near future.

[iii] op.cit. SEU June 2004, also ODPM, *Action on mental health; a guide to promoting social inclusion*, (esp. Factsheet 6 – Mental Health and Housing. ODPM, (Oct 2004)

[iv] Al-Khudairy, *The changing idea of community*, in *Dialogue and dwelling, a therapeutic community approach to care in the community*, Ed Tucker, (2000)

[v] Meltzer et al The social and economic circumstances of adults with mental disorders, Office of National Statistics, 2002

[vi] Meltzer et al , op.cit

[vii] Slade M, et al *Risk factors for tenancy breakdown for mentally ill people*, Journal of Mental Health, 1999

[viii] From earlier interviews with clinician staff: there are few systematic studies on the social – rather than medical – triggers for admission.

[ix] Odell SM, Commander MJ, *Risks factors for homelessness among people with psychotic disorders* Soc Psychiatry Psychiatr Epidemiol. 2000 Sep;35(9)

also Bines, W., *The Health of Single Homeless People*. University of York 1994

also Thompson, D., *Mental Illness:the Fundamental Facts*, Mental Health Foundation 1993

also Gill, B et al. *OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 7:Psychiatric morbidity among homeless people*. HMSO 1995

also Joint Forum on Mental Health and Homelessness, *Mental Health and Homelessness:The Facts*, 1996
and many other similar articles.

[x] Harkness j, Newman SJ, Salkever D: *The cost-effectiveness of independent housing for the chronically mentally ill: do housing and neighborhood features matter?* Health Serv Res. 2004 Oct ; 39(5): 1341-60

also *Proceedings of Harvard School of Public Health Symposium on Housing, Neighbourhoods and Health*, 2003

also Caughy MO, et al *When being alone might be better: neighborhood poverty, social capital, and child mental health.*; Soc Sci Med. 2003 Jul;57(2)

also Newman SJ. *The housing and neighborhood conditions of persons with severe mental illness.* Hosp Community Psychiatry. 1994 Apr;45(4)

also Caspi A, et al *Neighborhood deprivation affects children's mental health: environmental risks identified in a genetic design.* Psychol Sci. 2000 Jul;11(4)

[xi] Glover GR, Leese M, McCrone P. *More severe mental illness is more concentrated in deprived areas.* Br J Psychiatry. 1999 Dec;175:544-8

also Kai J, Crosland A, *Prevalence of enduring and disabling mental illness in the inner city*: Br J Gen Pract. 2000 Dec;50(461)

also Macpherson R, Haynes R, Summerfield L, Foy C, Slade M. *From research to practice: a local mental health services needs assessment.* Soc Psychiatry Psychiatr Epidemiol. 2003 May;38(5): 276-81

[xii] Hanrahan P, et al *Housing satisfaction and service use by mentally ill persons in community integrated living arrangements*; Psychiatr Serv. 2001 Sep;52(9)
NB: high-rise accommodation, in particular, is often identified by users – and particularly by carers – as unsuitable; yet pressure on housing stock means that it is often all that is available.

[xiii] Ellaway A, et al *Mums on Prozac, kids on inhalers: the need for research on the potential for improving health through housing interventions.* Health Bull (Edinb). 2000 Jul;58(4)

also Latkin CA, Curry AD. *Stressful neighborhoods and depression: a prospective study of the impact of neighborhood disorder*. Health Soc Behav. 2003 Mar ;44(1)

[xiv] Blackman T, et al *Change in adult health following medical priority rehousing: a longitudinal study*; J Public Health Med. 2003 Mar;25(1)

also Elton PJ, Packer JM. *A prospective randomised trial of the value of rehousing on the grounds of mental ill-health* J Chronic Dis. 1986;39(3)

also Leventhal T, Brooks-Gunn J. *Moving to opportunity: an experimental study of neighborhood effects on mental health*. Am J Public Health. 2003 Sep;93(9)

[xv] See for example Littlewood and Lipsedge *Aliens and Alienists*, Pelican, 1982 and many other similar articles.

[xvi] Wilson, M., Francis J., *Raised Voices*, Mind Publications, 1997

also Guite, H et al., *Diversion from courts and prisons to psychiatric inpatient care in a district*. Unpublished report, Dept. of health and epidemiology, King's College London, 1996

also Browne, Deryck, *Black People and Sectioning,* Little Rock Publishing, London 1997

also Cochrane and Bal, *Mental Hospital Admission Rates for Immigrants to England*, Social Psychiatry, 24, 2-11, 1989

also Cochrane, R., Sashideran, S. *Mental Health and Ethnic Minorities: A Review of the Literature and Implications for Services*. Report available from Professor Cochrane, School of Psychology, University of Birmingham (undated)

also Fernando, S., *Mental Health, Race and Culture*, Mind Publications 1991

also Nazroo, J., King M., *Psychosis – symptoms and estimated rates*, in Sproston, K., Nazroo, J., (ed) *Ethnic Minority Psychiatric Illness Rates in the Community* (Empiric), National Centre for Social Research, TSO, 2002

also Nazroo, J.Y, *Ethnicity, Class and Health*, Policy Studies Institute, 2001

[xvii] http://kc.nimhe.org.uk/

[xviii] Leventhal T, Brooks-Gunn J. op.cit.

also Harkness j, Newman SJ, Salkever D, op cit.

[xix] A range of examples of "joined up practice" should be available via the NIMHE website in the course of the autumn of 2005.

[xx] ODPM, *Creating Sustainable Communities: Supporting Independence,* ODPM, 2005

[xxi] Halpern D, *More than Brick and Mortar: Mental Health and the Built Environment*. Taylor & Francis, 1995

also Rogers A & Pilgrim D, Chapter 2, *Mental Health and Inequality, 2003*

[xxii] see Wilmott P and Murie A, *Polarisation and Social Housing*; Policy Studies Institute 1988

also Ravetz A, *Council Housing and Culture; The History of a Social Experiment*; Routledge 2001

[xxiii] Pawson H, *Perpetuating Polarised Neighbourhoods? Rehousing Outcomes in the Housing Association Sector*; paper to Housing Studies Ass. Conference, 2003

[xxiv]Carer's Council, Nottingham, 2000

[xxv] Audit Commission, *ALMO inspections and the delivery of excellent housing management services, Housing Guidance paper*; Audit Commission, 2003
NB: The only corporate aims that are specified[xxv] in relation to housing stock development are those relating to energy conservation and environmental impact, employment, and community safety.

[xxvi] *Criteria for assessing core standards : Information for mental health services and learning disability services*; Healthcare Commission 2005-06-11

[xxvii] NACAB, *Possession action – the last resort?* NACAB 2003

[xxviii] SITRA, Nigel Rogers, personal correspondence, 2003

[xxix] Ravetz A, op cit.

[xxx] For a useful discussion of the relative balance of residualisation and labelling as factors, see Goodchild B, *Housing and the Urban Environment*, chapter 5 – *The renewal of "problem" estates*; Blackwell Science, 1997

[xxxi] Johnson R, *An idea whose time has come? Mental health, social inclusion and housing*. In *Housing Care and Support*, Pavilion (Feb 2005)

See also the NIMHE website: www.nimhe.org.uk/home